



Wicked Bad Habits: Governing Women in the Carceral-Therapeutic State in Massachusetts

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Wicked Bad Habits:
Governing Women on Heroin in the Carceral-Therapeutic State in Massachusetts

A dissertation presented

by

Kimberly Lauren Sue

to

The Department of Anthropology

in partial fulfillment of the requirements
for the degree of
Doctor of Philosophy
in the subject of
Anthropology

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ABSTRACT

Wicked Bad Habits: Governing Women on Heroin in the Carceral-Therapeutic State in Massachusetts

In this dissertation, I focus on the social response of criminalization and incarceration to the problem of heroin use among women in Massachusetts in the ongoing era of the United States' "War on Drugs." Based on fieldwork conducted between 2010-2014, I argue that the convergence of therapeutic ideals with the prison system creates a means of governing and regulating these women's lives via what I call the "carceral therapeutic state." I examine various facets of treatment programs in the state women's prison, MCI-Framingham, and a local Boston jail, Suffolk County House of Corrections, including drug treatment, trauma treatment and work readiness programs. I consider how and why these programs in prisons and jails have become means to centralize and solidify the criminal justice system as the predominant site of addiction and mental health treatment for poor women on drugs.

Over the past eighteen months, I have followed women with opiate addictions recruited from the prison, the jail, and a local community suboxone clinic over time as they traverse many spaces: their homes, the streets, hospitals, shelters and back into prisons and jails. These women struggle mightily with the task of recovering from drug addiction as well as incarceration itself. I explore the dilemmas they face during and after incarceration as they struggle for well-being and for moral lives amidst many sources of everyday violence and harm, including themselves. I also consider how political and moral valuations of women who use drugs are based on a particularly American notion of selfhood, volition and health.

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Author's Note

The names of all my informants and their identifying information have been changed in this work to protect their anonymity. I tended to leave officials in the prison administration nameless unless they were invoked as an authority or as a public figure or personage. Since there is political sensitivity around this issue, I have endeavored to approach the topic delicately in order to access the opinions and experiences of people who work in prison and jail systems as well as individuals who have been incarcerated there.

The prison and the jail are public identifiable institutions and I have identified them by name throughout the text (although I have anonymized the clinic). The historical specificity, as well as their nature as public institutions, made an argument for the use of real names. In anthropology, context and history are critical. While this jail and prison have specific histories and orientations, I endeavor to show how attitudes and policies they utilize are representative of a larger American cultural and political alignment toward drug use and deviance more generally.

Chapter 1: Introduction

*Best of luck to those bestowed with dark talents
and no good fortune --- I've seen them wake up
on sea shores and light cigarettes
as only those who long for
teasing and tiny caresses can -- Best of luck
to these nomadic proletarians
who put their heart in everything*

-Roberto Bolano

Scene 1:

Mae's face smashes off the dashboard of a light blue 2002 Toyota Camry. She is only 21, a little petite girl constantly fretting about staying little and petite. She is sitting in the passenger seat next to her mother, Janet, who is clutching the steering wheel at ten and two with white knuckles. Mae's boyfriend, Matt, a gangly 6' 4" charmer, is sitting in the backseat behind Mae and grabs at the back of Mae's head. She is deadweight, her jaw closed tightly upon itself, like a tiny green fiddlehead fern coiled around a single spoke.

"She's dying, she's overdosing, Janet!" Mike screams, panicking from the backseat. He and Mae have been dating for six years and they do everything together, tried and true "running" partners. Someone to depend on in a clutch, someone to entertain ridiculous shenanigans to hustle for money, someone to make sure you didn't overdose and die alone in the decrepit bathroom of a Dunkin' Donuts. Mae was the reason he started shooting up in the first place. She was the one to inject him for the first time, an act of love until the love was mostly between him and the needle. Then they shared a mutual love of the needle and the quest to get heroin to fill it.

Mae had learned how to inject heroin in a detox facility in South Boston after she went in for a bad habit: snorting Perc30s. Someone at the detox showed her how to do it and within a week, Mae was doing it herself and also for Mike. The people at the detox didn't look so terrible

to Mae; they looked like lovely, normal people. But you know what they say about detoxes: nothing to do but talk.

Janet is pressing the accelerator with increasingly uncontrolled urgency, looking panicked over at her daughter's slumped body. They speed down the darkly wooded two-lane street towards home after scoring some heroin in a nearby town and using together. A rural local fire and police station, a pizzeria, a gas station all pass by in a blur. Janet protests, "No, I have shit on me. We can't stop." Janet is 55-years-old and jealous of her daughter's youth. She is thin and haggard-looking, a tired mom with gray hair and a smoker's face. She has always been attracted to drugs as way to trick herself that her life is more exciting than it really was: first crack cocaine since Mae was little, then Xanax, and now heroin. She fights the battle against her aging body in pursuit of narcotized solace with Mae and her friends, her drug connections. It allows her to temporarily forget her adult responsibilities and reach back into a youthful oblivion. Her daughter thinks she is pathetic but allows it to continue so she can get free drugs.

Mike insists, "Your fucking daughter is overdosing right now! She is dying. Pull into the station now Janet! I will grab this wheel and rip this car right into the fucking woods right now. You better turn around. Throw the shit out the window."

Janet hesitates in agreement—fine, she eventually shouts— and Mike fumbles in the car for all the stuff strewn around the handbrake. He pulls out empty bags of heroin that they had tried in vain not to use up completely, the needles, the caps. Janet reaches into the pocket of her jeans and pulls out a waxy bag of heroin that she had bought for tomorrow, for the wake-up shot. He grabs it all and crams it into a plastic pencil case. He throws it out of the window. It falls feebly towards the woods, still visible to the road. The car is punctuated by Mae's eerie silence. She is usually a talker, a giggler, mumbling, laughing, always making noise.

Janet turns the car around. When they pull into the station, Mike runs out of the car screaming, “My girlfriend’s overdosing, she needs to be Narcaned [given an opioid overdose reversal medication].” Several men run to the car and grab Mae out of the front seat. Janet sits, frozen, fumbling, still anxious even though they disposed of the “shit.” The paramedics transport Mae to an ambulance and the heavy doors swing shut. Mike and Janet pace outside the ambulance. Mike’s heart is throbbing with certainty that Mae is dead inside that ambulance.

One of the paramedics gets intravenous access—Mae usually uses several veins in her right arm and hand—and he administers her intravenous naloxone. No response. He waits and gives her another. Mae comes to. Her first sensation is that her jaw is clamped tight shut. She works to open it with her hand.

“Can you just get me something?” she asks groggily. “I’m not even feeling it.” She thinks the paramedic is her boyfriend and she is asking him for some more heroin.

“We’re going to Narcan you again,” the paramedic says.

“No,” her voice trails off. “I’m fine.” She started to go back out again, to settle back into unconsciousness. She thought it was Mike who was touching her. Why are you touching me, she thought angrily. Give me a fucking cigarette. She starts to wriggle around on the table. Why are you holding me down, what is wrong with you? She thinks the paramedic is her boyfriend holding her down. She has a quick moment of realization that this person is not her boyfriend. Oh, this is not good, this is not good.

“You overdosed. You’re going to be okay.” They all say it the same way, slowly and a little too loud.

The few seconds of realization were stressful. “Can I just have a cigarette?”

The feeling of overdosing was just too good. Mae overdosed two more times within the week. The same doctors and nurses treated her each time, telling her sternly, “You’re going to die. What are you doing?”

“It’s fun,” she tells them, shrugging.

Scene 2

Boston, 1977. It’s summertime and the nights are heavy with humidity lingering from the harbor and the nearby Charles River. The urban underbelly opens itself up to play at night. The “Combat Zone,” several blocks zoned exclusively for “adult entertainment” was the name for some parts of Downtown Crossing and Chinatown (Giorlandino 1986). It was an urban planner’s attempt to contain all the vices of a big little city in one small region populated by erotic bookstores, “all color” theaters, gambling, strip clubs, peep shows for 25 cents a pop, “private viewing booths.” Two *Boston Globe* reporters noted that places like the Combat Zone always seemed to exist “as long as society, and life, has the ability to maim, and then ostracize the maimed, there will be a place for the maimed and the ostracized... a place where all acts and people who commit such acts, rejected by society, congregate” (Kneeland and McDonald 1966: D6).

The “Combat Zone” ate up everyone who came to play, equal opportunity for destruction or bliss. A Harvard football player was stabbed to death in a robbery gone awry, a married Tufts associate professor of anatomy murdered his stripper girlfriend, the House Ways and Means Chairman Wilbur Mills danced onstage at a burlesque house, ruining his political career. Everywhere you turned there was some vice to indulge, some way to court danger: the Pussycats, the Naked I Lounge, the Glass Slipper, they all promised beauty and danger and vice.

Jean was 14-years-old, really just a child trying to find love and acceptance that she never received from her mother or her stepfather. The product of a mixed-race partnership, an absent black father, you probably know the storyline. She hadn't done well in school and all her mother did was fight, hurling curses and epithets at her stepfather and at her three other children that were a daily reminder of the transient men in her life.

When Jean was 14, she just “walked away,” leaving the small-town in the South Shore that her family had settled in as her stepfather sought work as a brick-layer. There were no frantic calls from her family to the police, no runaway reports. She made friends with a group of nomadic teenage girls after she scraped up enough money begging in the Common to buy herself a slice of pizza and a Coke. She followed her new friends into an alley in pursuit of a good time. She was too young to be properly scared of the alley off the intersection of Beach and Essex Streets in Chinatown. Her new friends wouldn't lead her astray and she wanted them to like her.

Jean had tried drugs before. She had been in the habit of occasionally stealing her grandfather's beers from the refrigerator since she was ten. She had smoked weed and even done quaaludes. She had sniffed some lines of coke with an older boyfriend. But she had never done dope, heroin, H, smack. The basement room they entered was dark, full of broken beer bottles, trash and dirty mattresses on the floor holding groups of people in various states of euphoria. Sugar, the ringleader of the group of teenagers, told Jean to offer up her virgin arm. It's fun, she said, you'll like it.

Someone tied a belt, a tourniquet around her skinny girl arm, a noose closing over a future that was never that bright anyways. Jean squeezed her arm and shut her eyes. Sugar saw a flash of blood, then emptied the chamber into Jean's arm. Was it over? She looked down at the needle in her arm and felt a wave of nausea rush over her. Then blindness.

“Where’s the bathroom?” she managed to ask. She ran toward the dirty toilet in the dark shooting gallery, hugging the bowl, vomiting the pizza she had just eaten.

“What the hell? Why do people do this shit? Everyone else seems to like this and I’m throwing up.” Jean thinks that she got a “bad batch” so the next day, she tries it again. After all, she is staying with Sugar now so it just becomes part of their daily life. Then, all of a sudden, “I started waking up craving it.” In the beginning, it was hard for Jean to hit herself. She had to pay people, give them some of her dope, so that others would shoot her up. But as generous as heroin addicts can be, sharing dope becomes old. It always creates tension. The dope becomes all-consuming. It progressed from a semi-social activity to “locking herself in the bathroom for hours.”

Money in the Combat Zone came fast and easy. The drugs were plentiful. Jean able to use her oddly angled features and her childlike demeanor to chat up men who would take care of her, set her up in apartments in Dorchester and Roxbury that they kept on the side, hidden from their wives. She was able to do it all: buy some nice high heels, shop, shoot dope, go to a different club every night. Older men, her “sugar daddies,” paid for her car, her rent and gave her a little spending money on the side. But they were respectable, middle-class black businessmen in Roxbury with families and they didn’t like dope. They liked a little bit of danger but not that kind of danger. One of her sugar daddies found out about her secret habit at breakfast in a greasy spoon diner. She had gone into the bathroom to shoot a speedball (cocaine and heroin mixed together in one injection)—it was a bad day if she had to shoot just plain dope in the morning—and she had nodded out into her pancakes. He made her pack her bags and leave immediately.

The only time in the next thirty years she would stop using heroin was when she was in jail. “That was my detox, I’d go to jail. Whatever sentence I had—three months, six months, a

year—I'd stay clean for that amount of time. When I'd get out, I'd go back to the same people, same everything and it would start all over again." Jean thinks maybe she wouldn't have used for so long if she had a family that actually cared. Maybe then she would have tried to get treatment outside of jail.

Mae and Jean could not be more different on the outset, although they share a mutual love for heroin. Mae seemed to have it all, growing up in a town where her classmates pouted about getting a Lexus instead of a BMW for their 16th birthdays. Jean, on the other hand, had experienced emotional and physical abuse at the hands of a neglectful, mentally ill mother, her childhood cut short and largely defined by her sense of unimportance. If they ever met during active heroin use, Jean would have most likely tried to rob Mae for drugs or money. Mae might have eventually charmed Jean, and they might have run the streets together briefly.

But they probably would never have met. Jean didn't leave a familiar set of geographic nodes connected by poverty, drugs, treatment programs in the South End-Roxbury-Dorchester-Chinatown circuit. Mae had a consistent dealer in the wealthy suburbs where she lived and never felt the need to go all the way to Boston, especially when her mother was buying drugs for them. But one place that Mae and Jean might have met was at the state prison for women, MCI-Framingham in Framingham, Massachusetts, where both served time for drug-related crimes.

For all their differences, Mae and Jean are the faces of the "War on Drugs" in Massachusetts. And the story in which Mae and Jean are bit players is, at its core, a story about how some substances and people become symbolic of danger, contamination and badness, posing as threats to safety, virtue, upright living, and public morality. What happens to these women after they are marked as dangerous, bad and criminal is largely unwitnessed, unnoticed

and swept under the rug in a political environment in which drug addiction has little sway other than to cause the downfall of politicians too indiscreet to partake in clandestine consumption.

This is a story in which women who use some kinds of drugs in some kinds of places become reconfigured and reconstituted as criminals and what Derrida calls the “mystical foundations of authority” (2001) largely go unchallenged and even fueled by the desire not to know about the lives of others we so harshly police and punish. The law intercedes in the lives of most people in the United States, but among poor drug users it especially rears its head in a myriad of violent, jarring ways. As people of all classes engage in the purchase and consumption of a staggering array of pills, potions and charms “in the name of freedom in order to maximize our health, wellness and happiness” (Mackenzie 2006: 92; see also Saris 2010), only the consumption of the poor is heavily policed, regulated, and viewed as pathologically excessive and out of control.

As the anthropologist Stephen Hugh-Jones has noted, the concept of what a “drug” *is* must be intimately linked to a particular matrix that supports it: “A state established judiciary, police force and customs together with specialized and monopolistic medical and pharmacological professions... the concept also depends on a historically and culturally specific classification of substances and on a specific set of rules norms and conventions concerning the appropriate ways in which these substances are to be distributed and consumed” (1995:48). Heroin interests me because of the medico-legal matrix that enshrouds it. I am not interested in the physical dangers or “hardness” of heroin so much as I am interested in the increasingly medicalized views of its treatment and the way in which opiates have historically blurred the lines of “licit” and “illicit” use.

Heroin is a unique substance that differs from alcohol, cocaine and tobacco in that it tends not to enhance social interactions. Who wants to access the feeling of dissociation from reality that heroin offers? It turns out, many people do. And it leads many people to prison because possessing, using or otherwise selling heroin is illegal. Turning the ethnographic lens to the prison itself, I hope to show how heroin use, addiction and its treatment have been constituted as social problems whose solution is offered, perpetuated and complicated by the rise of the carceral-therapeutic state. I use the term carceral-therapeutic state to describe our contemporary set of carceral institutions –ostensibly for punishment, confinement and containment of criminals—that is increasingly dominated by therapeutic ideologies and processes. Among a diverse and varied drug treatment industry, how have carceral institutions become the largest mental health and addiction service providers for the poor?

Here I build on a long tradition of drug ethnographies as a way to peer at the dominant social order from the margins, dating back to the Chicago School work of Robert E. Park and Georg Simmel in the 1930s and their students, including Alfred Lindesmith, Bingham Dai, Howard Becker and many others (Singer and Page 2011:36). Anthropologists have used social deviance—in this case, drug use—more generally to think through difference. As Margaret Mead wrote, the deviant was anyone “who because of innate disposition or accident of early training, or through the contradictory influences of a heterogeneous cultural situation, has been culturally disenfranchised, the individual to whom the major emphases of society seem nonsensical, unreal, untenable, or downright wrong” (1935: 271).

Critical ethnographies of drug use draw our awareness to the uneven playing field upon which the poor precariously build their lives. Such an ethnographic lens is also necessarily a focus on power relations, on structures and policies of the state, and on institutions and

discourses that perpetuate or exacerbate social inequalities. As Philippe Bourgois and Jeff Schonberg summarize the task of anthropologists of drug use, we must “clarify the relationships between large-scale power forces and intimate ways of being in order to explain why the United States, the wealthiest nation in the world, has emerged as a pressure cooker for producing destitute addicts embroiled in everyday violence” (2009:5). A focus on drug use allows anthropologists to not only look upward at the programs of the powerful but also inward to the emotional and mental life of the subjected individual. This story looks at interventions in the lives of heroin users in the name of health and sickness with incarceration as the preeminent social response. How do the bodies of female heroin users become sites of governance, made into criminals by state decree? How has drug treatment and therapeutic ideals of well-being become enmeshed in, appropriated and consolidated within the realm of punishment?

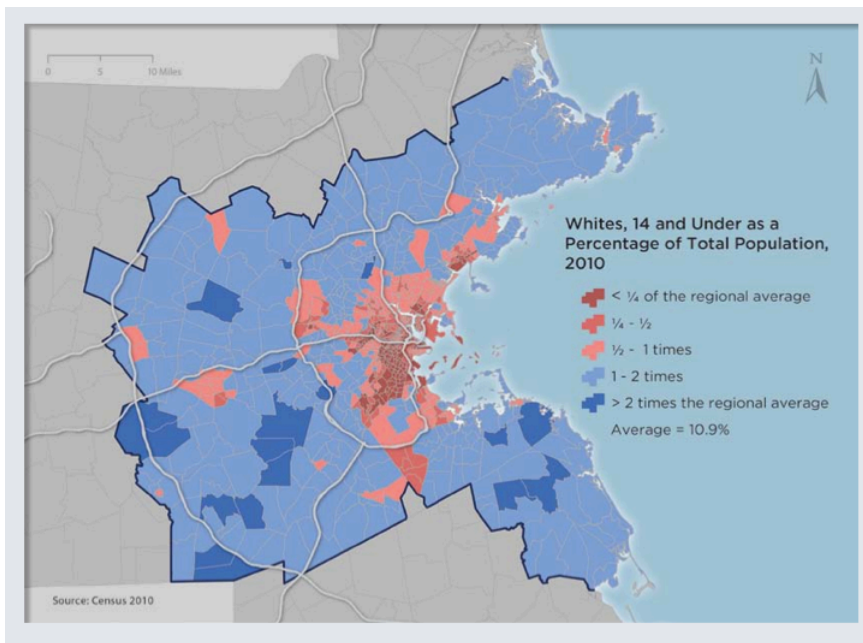
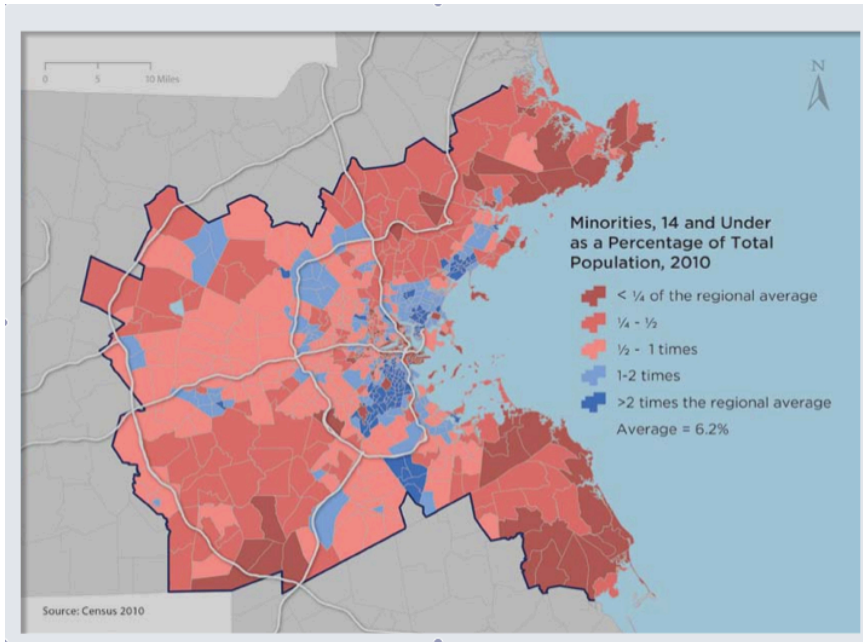
City of Neighborhoods

This story is about Boston, Massachusetts, and the small towns nearby that also call it home. Also known as the “Hub” of the Universe (originally called the “Hub of the Solar System” by Oliver Wendell Holmes), the Cradle of Liberty, the City on a Hill, the Puritan City, Beantown. The largest city in New England, and one of the oldest cities in the country, Boston was founded by the Puritans in 1630. It is a small “big” town; the population of Boston proper was 636,000 in 2012 (the Greater Boston area is 4.5 million). According to the latest census data, the population of Boston is approximately 54% white, 25% black, 17.5% Hispanic and the largest ethnic group are people of Irish descent, approximately 16% of the population of the city, followed by Italians at 8.3% (U.S. Census Bureau 2014).

Boston has as many facets as it does nicknames. It has a reputation as a city of cultural elites, of top-tier universities, of fervent dedication to many major league sports teams. It is also a primarily left-leaning city; the politics heavily influenced by unions representing working-class Irish and Italian immigrants. And like its other contemporary urban counterparts, Boston has an inequality problem. According to a recent report, the greater Boston area is less equitable than 85% of other urban areas in the United States (Metropolitan Area Planning Council 2011).

Wealth tends to be distributed by neighborhood and the neighborhood is a critical unit of analysis. The City of Boston website calls Boston a “City of Neighborhoods” and the politics of Boston neighborhoods is fierce.¹ Boston is also one of the most racially segregated major urban cities in the United States. The ongoing segregation negatively affects educational outcomes, tolerance of others and economic and political participation (Logan, Oakley, and Stowell 2003; Lee 2004; McArdle 2003).

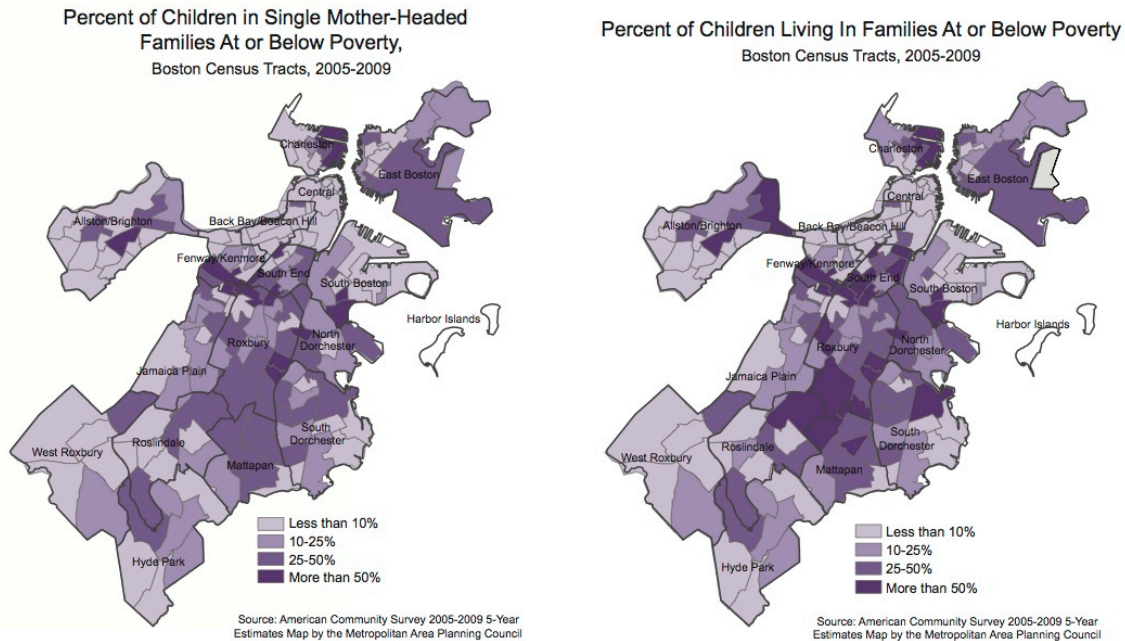
¹ Of its 21 officially designated neighborhoods, they write, “Indeed, Boston’s strength, diversity and vitality are all rooted in her neighborhoods, where neighborhood pride and cultures from all over the world are cherished and celebrated.” For those unfamiliar with Boston’s neighborhoods, a brief summary: The old money aristocratic Yankees (nicknamed the Boston Brahmins for their status, wealth and influence), descended from Mayflower Pilgrims, live in the Back Bay or Beacon Hill. Equivalently wealthy white enclaves—perhaps newer money and less pedigreed—went to live in Newton, West Roxbury, Brookline and Cambridge. African-Americans have lived in Dorchester, Roxbury and Mattapan, although Dorchester has a high rate of Vietnamese immigrants, Jews and Polish. Dorchester is also home to many Irish immigrants as well. South Boston (known colloquially as Southie), East Boston, and Charlestown are home to poor or working class whites, often of Irish or Italian descent. Chelsea, another poor working class neighborhood, is home to poor whites and increasing Central-American and African immigrants.



Map 1.1: Boston neighborhood segregation (State of Equity in Metro Boston Indicators Report, 2011, p. 20)

It is also very segregated by class, with the poor whites living in South Boston (Southie), Charlestown, and East Boston although much of that is changing with gentrification and immigration. The physical and cultural separations between neighborhoods became apparent

during the Boston busing era and mob violence famously chronicled in a Pulitzer-prize winning book, *Common Ground* (Lukas 1985).²



Map 1.2: Poverty levels by neighborhood (Kahn and Martin, *The Measure of Poverty Report*, 2011, p. 10)

My ethnographic fieldwork took me on a tour of many of Boston’s neighborhoods. I traveled to East Boston, where one of the women in my study sold cocaine for her Italian uncle in the Teamsters. She worked on the Big Dig in order to conceal her rapid and large income at the time. I chose to live in Roxbury, close to both the jail and the hospital that were my fieldsites, and the neighborhood welcomed me warmly. I lived somewhat warily between two warring

² In the book, Anthony Lukas documents the experiences of three families—one Yankee aristocratic, one black family from Roxbury, and one “Townie” (Charlestown Irish) family—during busing and forced integration of the Boston public school system in the 1970s. Lukas writes of a new era with a new Boston mayor: “So a new Kevin White [mayor of Boston] began to emerge during 1971. He downplayed his Office of Human Rights, Model Cities, and other programs designed to aid the black community, while talking tough on crime and drugs, beefing up the police, and promising to hold the line on taxes” (1986: 210). The busing situation that ensued would pit poor white neighborhoods versus poor black neighborhoods: to ensure equal racial distributions, Charlestown students were bused to Roxbury, and South Boston students were bused to Dorchester. Racialized and class violence swept across the city; race relations were tense. Wealthy white neighborhoods like West Roxbury were criticized for not having to sully their hands with the forced busing.

gangs, Bromley-Heath and the H-Block (Humboldt Street) in the first-floor of a crumbling Victorian house. The violence was very real; someone was murdered on the intersection of my block while I was away. I called the police once when a large group of teenage girls began fighting in the street outside my house at 3am one night and four of the girls got in a car and threatened to run the others over.

Roxbury was only a hop, skip and a jump away from the South End. And in the South End were the Lenox Hill housing projects, still to this day a prime location to buy heroin. I also went to Dorchester, where the block's cocaine dealer, a heating and air conditioning repairman with a Mercedes-Benz, invited me and my informant to go to the gym with him and then eat salads at Wendy's together afterwards.

I also traversed the suburbs north and south of Boston—the neighborhoods that are not exactly Boston proper, but that are inextricably tied up with Boston's economy, history and politics. These are largely working class suburbs that are satellites of Boston on the North and South Shore: Lynn, Malden, Everett and Chelsea to the north, Brockton, Randolph, Abington, Quincy on the South (Scharfenberg 2013). So while this is a story about Boston, it is also a story about Boston's geographic radius in which the poor are increasingly pushed out to neighborhoods like Lynn ("Lynn, Lynn, the city of sin, you never come out, the way you went in") or the projects in Malden or Everett. It was the kind of poverty that is not so visible, flashy and extreme as street or shelter homelessness but in many ways just as despairing and tragic.

Maps of Boston's neighborhoods reveals how inequality tracks historically and by place and these "neighborhood effects" (Sampson 2012) heavily influence one's life chances.³ A

³ Robert Sampson's analysis of the "neighborhood effect" is helpful for providing a theoretical framework to think about city spaces and the role of the built and natural environment. He argues the neighborhood level is an important mediator of individual choices and city and state-wide policies: "Humans react to neighborhood difference, and these reactions constitute social mechanisms and practices that in turn shape perceptions, personal relationships, and

recent Boston mayoral candidate, John Connolly, noted that, not unlike many other large cities in the United States, “We are increasingly a city of the very rich and the very poor.” The Boston Indicators Report commissioned by the Boston Foundation in 2011 showed that the “poverty in Boston is highly concentrated, demographically and geographically” pointing to Roxbury, Dorchester, and Mattapan, where 40% of the children in those neighborhoods lived in poverty (Kahn and Martin 2011:10). The report also showed that while Boston was overall a highly educated city, with 40% of adults overall having a 4-year college degree, in the Roxbury/Dorchester/Mattapan neighborhoods, between 20-40% of the adults did not have a high school diploma (Kahn and Martin 2011: 11).

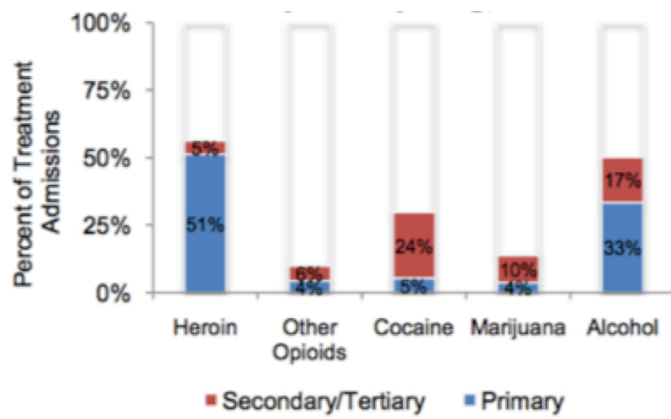
Health disparities largely tracked along neighborhood and racial lines, with higher infant mortality rates, homicide, asthma and hospitalization among black Boston residents than white Boston residents (white Bostonians had higher drug-related mortality, suicide and lung cancer mortality than black residents); black women and men both had lower average life expectancies than white men and women (Ferrer 2008). The Boston Public Health Commission, reporting health data by neighborhood, showed that rates of chlamydia, syphilis, gonorrhea, obesity and heart disease tracked geographically; Roxbury, Dorchester, and Mattapan had statistically significantly higher rates of these conditions than the rest of Boston (Boston Public Health Commission 2013). Not surprisingly, violence tracks along these neighborhood lines as well (Braga, Papachristos, and Hureau 2010). These unequally distributed bad health outcomes are a

behaviors that reverberate both within and beyond traditional neighborhood borders, and as a whole define the social structure of the city” (Sampson 2012: 357). Geography-based inequality between neighborhoods is a both “a consequence and a cause” (Sampson 2012: 358). Growing up in a neighborhood that is perceived to be “bad,” like Roxbury, for example, matters because people behave and “act as if neighborhoods matter” (Sampson 2012: 59). Of particular interest to Sampson is the economic and racial segregation that leads to “the concentration of cumulative disadvantage” (2012: 154).

complicated convergence of forces, including environmental factors, stress, racism and differential access to care and treatment.

Overlaid onto this grid of concentrated disadvantage by neighborhood and often fraught relationships between neighborhoods is the issue of drug use. Nationally, research suggests that illicit drug use is roughly equally proportioned by racial distribution (7.4% for blacks, 7.2% for whites and 6.4% for Latinos), yet since the population of white Americans is so much larger than of black and Hispanic Americans, the total number of white drug users is much greater (Moore and Elkavich 2008: 783). Moore and Elkavich attribute the disproportionately high rates of incarceration for poor people of color largely to the fact that “drug use in suburban areas goes unchecked and underreported, while people of color are profiled in urban areas as potential drug dealers and users” (ibid). Who goes to prison or jail for what drugs is not based on the actual potential for harm in many cases, but who is policed (Golembeski and Fullilove 2005; Alexander 2010).

Drug use in Boston includes what you would expect from any big city: alcohol, marijuana, heroin, cocaine, amphetamines, ecstasy. Heroin was the most frequently cited reason for entering detoxification or treatment in 2010, comprising 56% of the admissions, even more than alcohol. It was also one the top “drug of choice” for substance use treatment in Boston in a comparison of drug treatment admissions among 22 major metropolitan regions (Community Epidemiology Working Group (CEWG) 2012).



DATA SOURCE: Massachusetts Department of Public Health, Bureau of Substance Abuse

Figure 1.1: Substance abuse treatment admissions by primary drug, secondary/tertiary drug, 2010 (Boston Public Health Commission's Substance Abuse Report 2011, p. 26)

CEWG Areas	Alcohol	Cocaine/ Crack	Heroin	Opiates/ Opioids Other Than Heroin	Metham- phetamine	Marijuana	Benzodiaz- epines	Other Drugs
SOUTHERN REGION								
Atlanta	1	3	6	4	5	2	7	8
Baltimore City	2	4	1	5	8	3	6	7
Maryland	1	5	2	4	8	3	7	6
South Florida/ Broward County	3	4	7	2	8	1	6	5
South Florida/ Miami-Dade County	2	3	5	4	8	1	7	6
NORTHEASTERN REGION								
Boston ³	2	3	1	4	7	5	6	8
Maine	1	6	4	2	8	3	7	5
New York City	1	4	3	5	8	2	7	6
Philadelphia	2	3	4	6	8	1	7	5
MIDWESTERN REGION								
Cincinnati	2	3	— ⁴	— ⁴	6 ⁵	1	5	4
Detroit	1	3	2	5	—	4	7	6
Minneapolis/St. Paul	1	6	3	4	5	2	8	7
St. Louis	1	4	2	5	6	3	8	7
WESTERN REGION								
Colorado	1	4	5	6	3	2	8	7
Denver	1	5	4	6	3	2	8	7
Hawaii	2	5	6	NR ⁶	1	3	NR	4
Los Angeles	2	5	3	7	4	1	8	6
Phoenix ⁷	2	5	— ⁴	4	3	1	NR	6
San Diego	3	6	2	5	1	4	NR	7
San Francisco	1	4	3	7	2	5	8	6
Seattle	1	4	3	6	5	2	8	7
Texas	1	3	4	6	7	2	8	5

Table 1.1: Top-ranked primary drug admissions by city, from the Community Epidemiology Work Group report, *Epidemiologic Trends in Drug Abuse*, 2012, p. 24

According to a survey of Boston high school students, one in three high school students perceived drug use to be a problem (Boston Public Health Commission 2011: 2). Use of marijuana in 2007 and 2009 showed no significant gender variations between white and black high school students, with roughly 25% reporting having used marijuana in the past month (2011: 5). Only 3% of high school students reported doing any other substances besides marijuana (2011: 7). Heroin was not that popular: ever having used heroin use was stable at 2%

in Boston public high schools from 2003-2009 with no significant differences by gender, race/ethnicity or age (2011: 9). In contrast, seven out of ten students reported ever drinking alcohol.

Boston remains a popular transit city for drugs as well as an endpoint for several important geographic and cultural reasons. It is a major transit hub connected by interstates and air and sea traffic with relative proximity to many regional metropolitan centers. It is a relatively short drive to New York City and exists as a large hub in a diffuse, loosely connected network of nodes that include Providence, Rhode Island, Hartford, Connecticut; upstate New York; Maine and Vermont. Boston is also home to a geographically diverse population that maintains drug connections in other states and regions around the world.

Heroin use as a “social problem” is a relatively recent phenomenon for Bostonians. In 1962, the police department “considered heroin addiction to be confined to a group of about 300 blacks between the ages of 21 and 30 and only two police officers worked the narcotics unit” (Taylor 1971). Yet in 1968, the newly appointed regional director of the Bureau of Narcotics and Dangerous Drugs, Richard A. Callahan, declared that heroin was no longer no longer “confined to ghetto areas” with heroin users “usually poor and unskilled” (Blake 1970). According to the media, it was now “mostly a white, middle class addiction that’s spreading with frightening rapidity” in “East Boston and the North End, Back Bay and West Roxbury” (Taylor 1971; see figure below for this neighborhood analysis of drugs and crime from this *Boston Globe* report). The geographic “confinement [to black neighborhoods] made everything seem all right” (Taylor 1971); lack of confinement bred terror and fear-based politics.

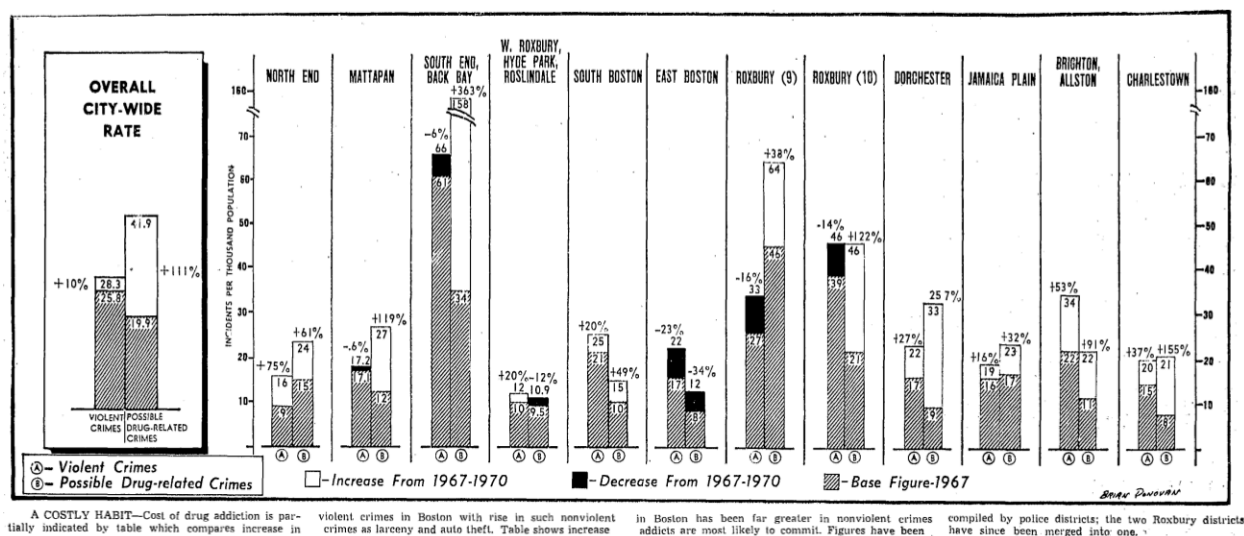


Figure 1.2: Drug crime by neighborhood, 1971 (Taylor, Boston Globe, 1971)

It was feared that heroin use was widespread, with an estimated 10,000 addicts in Boston in 1971 and Cambridge with an additional 3,000, a population second only to New York City (Whitten and Robertson 1972). Officials estimated that “at least 50 to 60 percent of the petty—that is, nonviolent—crimes in the city are committed by junkies because they have to steal to support their habits and they aren’t oriented, when hooked, to work” (Taylor 1971). At the time, heroin was coming into Boston through Logan Airport and specifically, the so-called French Connection through traffickers in Marseille synthesizing heroin from Turkish opium. Over the ensuing decades, the sources would change. According to the National Drug Intelligence Center, Dominicans control much of the heroin trade with Colombian heroin and Puerto Ricans in Lowell and Lawrence are also players (National Drug Intelligence Center 2001). While the Italian and Irish mafias historically controlled much of the heroin in Boston proper, Chinese and Central-American groups also entered the Boston heroin market.⁴

⁴ The FBI recently investigated drug-trafficking, gambling, extortion and prostitution activity in Chinatown, seizing over 12,000 oxycodone pills, 13 firearms, and \$480,000 in cash. Central to the Chinatown scene was a Caucasian man John Willis who went by the nickname Bac Guai John, or White Devil John (FBI Boston Division 2013).

The social response to the threat of drug use was clunky at best. Drug dealers were pegged as “murderers” and legislators debated if the death penalty was an appropriate punishment for “peddling” (Buckley 1973). One judge set \$1 million bail for a woman caught selling heroin claiming that “pushers are killing scores of people every day... that’s mass murder on a large scale” (McCabe 1972). There was a sense of futility, that drug addiction was a condition that could not be treated, especially heroin: “I never met an ex-addict,” said Capt. McDonald of the vice and narcotics squad (Jones 1971).

Drugs were not just in the Combat Zone or Roxbury and the South End. Michael Patrick MacDonald recalls growing up in the D Street Projects in Southie in the 1970s during the Boston busing angst, violence and racial turmoil in his memoir *All Souls*. He notes the omnipresence of Irish mobster Whitey Bulger in the neighborhood: “Whatever we had, we were going to keep. Whitey stepped up as our protector. They said he protected us from being overrun with the drugs and gangs we’d heard about in the black neighborhoods, as well as stopping the outsiders who wanted to turn the projects into expensive condominiums” (MacDonald 1999:110). He recalls the endemic poor-on-poor violence, drug use (in which his sister jumped off a building while doing a combination of cocaine, valium and speed) and an entrenched code of silence: “People in Southie didn’t trust the police” (MacDonald 1999: 204). Reported crime, or lack thereof, was not a good indicator of social harmony, order and the health of a community.

Neighborhood politics continue to influence local responses to drug use and crime. In a recent call for more “law and order”-based politics, the Massachusetts Legislature passed a bill known as the Habitual Offender Law, or the “Three Strikes” bill. In the fall of 2011, the vote in the Statehouse was 160-12 in favor of the bill; all the black and Hispanic members representing

the poor neighborhoods of color voted against it, along with four white colleagues.⁵ The Charles Hamilton Houston Institute for Race and Justice at Harvard Law School protested that it was an unduly harsh, ineffective and expensive policy (at \$40,000-\$60,000 a year for incarcerating one individual): “Other states are now rejecting habitual offender legislation... realizing that this type of legislation is too expensive and not effective in measurably reducing crime” (2012:14-15).

But the political bill was part of the more insidious “law and order” rhetoric and the trenchant claims for public safety among victim’s rights groups (the bill is also known as “Melissa’s Bill,” after a young teacher who was raped and murdered by a man who had been released on parole; there also was the high-profile incident of a Woburn police officer who was murdered by someone also released on parole). The media and the politicians knew that falling back on “public safety” and “law and order” rhetoric would give them the appearance of doing significant, yet the “moral panic” (Goode and Ben-Yehuda 1994; Cohen 1972) of the white middle-class around drugs and violence is a political reflex whose effects are felt primarily by poor communities of color. Sociologist Theda Skocpol gets at the heart of the issue: “Neither do these advocates [of targeted programs for the poor] explain why the American middle class and working classes will not simply want to write off troubled inner-city people, or else use repressive agencies—police departments, prisons, and a “war against drugs” to deal with their threatening behaviors. *Some voters feel better about punishing the underclass than about helping it*” (1991: 414, emphasis added).

⁵ At a community town hall meeting in Dorchester on the issue, there were a handful of people in an empty auditorium in the community center. Many local politicians were there, one of whom was Gloria Fox, a feisty elderly African-American woman who has represented Roxbury since 1987. She lambasted people for not engaging in activism against the bill—largely predicted to affect poor communities of color—and she was highly critical of the “number of empty seats here.” “You’re not the problem,” she yelled, “it’s all these people who aren’t here that is the problem.”

Even the costs of increased incarceration, with each inmate costing approximately \$45,502.19 in FY2011 and female inmates costing \$49,011, were acceptable to legislators (Massachusetts Department of Correction 2011: 6, 34). Governor Deval Patrick even actually proposed the construction of new prison and jail facilities under the rhetoric of being unable to provide decent “care” and “treatment” given that the chronically full prisons and jails would only get more overcrowded under the new law. In the ominously titled “Corrections Master Plan,” the state outlined a plan to address the 2020 projected needs of the prisons. The report outlined that the current prison system “has a current shortfall of approximately 9,800 bedspaces... expected to climb to approximately 10,250 bedspaces in 2020, requiring an estimated capital investment of \$1.3 to \$2.3 billion in today’s dollars and an increase of estimated annual operating costs totaling as much as \$120 million” (Massachusetts Division of Capital Asset Management 2011:1).

Incarcerating women was a special concern of the authors of the Corrections Master Plan at the state Division of Capital Asset Management: “The management of female offenders presents unique challenge to correctional administrators” (2011: 85).⁶ The plan for women included building more jails and prisons under the name “Regional Women’s Correctional Centers” to keep women closer to their home communities, requiring building 435-470 more beds. They also proposed building more beds for the mentally ill, more beds for pre-release facilities, more beds for sex offenders, and more beds for acutely medically ill prisoners, particularly the elderly. The bare minimum cost of Phase One of the prison expansion program is \$550 million.

⁶ They noted four characteristics of incarcerated women that made them different from men: 1) Prevalence of mental disorders; 2) Histories of physical and sexual abuse; 3) Separation from children; and 4) Prevalence of substance abuse (according to DOC in 2007, 86% of incarcerated women reported current or past problems with substances) (2011: 9-10).

Criminalization of Women on (Certain) Drugs

“Happiness might now be bought for a penny and carried in the waist-coast pocket” -Thomas De Quincey

The Habitual Offender Bill will even affect people who have been convicted of or agreed to guilty pleas for non-violent felony drug offenses. And the consumption and purchase of heroin remains is firmly embedded within the moral imaginary of criminality and within the existing legal apparatus. But why? Sociologist Troy Duster, in *The Legislation of Morality*, written in 1970 but with surprising resonance over forty years later, wondered why certain substances were criminalized and whose use was effectively made immoral. How was that moral order largely based on middle and upper class distinctions maintained in legislation? As he wrote, “Sustained use and addiction to barbiturates is far more debilitating than sustained use and addiction to heroin, yet heroin is illegal in both medical and nonmedical circles... the point should be made that the addictive properties of a drug have little to do with the social response to it to use” (1970:65). What Duster was concerned with was how certain substances became legislated as immoral: “History and logic reveal that there is nothing intrinsically moral or immoral about injecting an opiate into human body” (1970: 80).⁷

Women have sought the dissociative effects of heroin just as avidly as men have. Many important literary, musical and cultural icons have dabbled or become dependent on heroin or opiates, including the poet Samuel Coleridge, Jean de Cocteau, William Burroughs, Miles Davis, Lou Reed, Jim Morrison, to name a few. Among their female counterparts, Elizabeth Barrett Browning became a laudanum and morphine addict. Edith Piaf and Francoise Sagan were two

⁷ Of course, there is a matter of the manner in which substances are taken into the body and under what context. Intravenous antibiotic delivery in the context of hospitalization is life-affirming, necessary, and socially mandated in the name of health; intravenous heroin use, on the other hand, is dangerous, transgressive, violent, even gross, vile and subsequently bad.

famous “medical junkies” who depended heavily on morphine after accidents; the latter called drug use her “artificial paradise of nonsuffering” (Palmer and Horowitz 2000:143).

The singer Billie Holliday also lived for fifteen years with heroin addiction. She struggled to afford private sanitarium treatments to get clean: “With my salary from the Philly week... I could afford to get admitted to the best hospital in the country. Without it, they could hunt me down like a dog and send me to jail” (Palmer and Horowitz 2000: 128). Billie Holiday’s story is exceptional because she was so frequently pursued by narcotics officers and detectives keen on incarcerating her, while the drug use of other celebrities and musicians was and continues to be tacitly tolerated as these individuals claim to seek out expensive private rehabilitation or treatment. In her case, she received the criminal treatment—incarceration and ‘treatment’ at Lexington ‘narcotic farm’—if she was unable to afford her own expensive private sanitarium stays. Holiday’s story represents the turn to incarceration of (some kinds of) women on (some kinds of) drugs as a solution to drug addiction.

Women are one of the most rapid increases in prison populations around the country, increasing at disproportionately high levels than men (Bloom and Chesney-Lind 2003). The population of female prisoners has increased over 700 percent since 1977 (Tapia 2010); while men still vastly outnumber women, the rates of incarceration for women have been increasing faster than that of men, at an average rate of 4.6 percent per year from 1995-2005 (Harrison and Beck 2006). Approximately 80 percent of incarcerated women in 2005 were African-American or Hispanic (ibid). Much of the increase in female prison populations has been attributed to “War on Drugs” policies such as inflexible minimum sentences and “three strikes” laws that have ensnared women involved in low-level drug transactions (Anderson 2005).

In Massachusetts, as in much of the country, harsh “Truth In Sentencing” laws made it difficult for women to get released early on parole, a condition in which an individual can complete her sentence in the community under threat of revocation to prison (Massachusetts Sentencing Commission 2000; Ditton and Wilson 1999). A career prison administrator told me how they used to give out parole to the women “like candy,” but after “the cop killer” case in 2010 no parole board was willing to take the risk.⁸ The population of female inmates increased more quickly than national rates and also the rates for men: the population of incarcerated women increased 13% from 1997 to 2006 while the population of male offenders increased only 2% (Massachusetts Department of Correction 2006).⁹ Women’s crimes remain largely property, survival or drug-related:

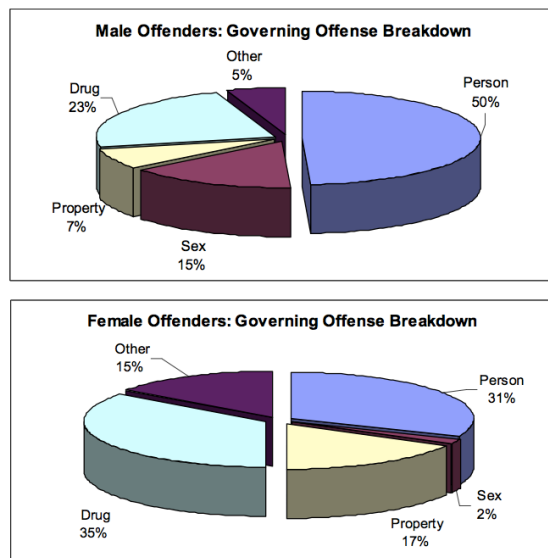


Figure 1.3: Offense breakdowns by gender, 2006 (Massachusetts Department of Correction Annual Report 2006, p.11)

⁸ Dominic Cinelli was released on parole in 2009 and killed a Woburn police officer even though he had been sentenced to serve three concurrent life sentences. Massachusetts had already a low rate of granting parole, with the sixth lowest rate of adults on parole per 100,000 residents and lower rates of parole granted for black and Hispanic inmates than for white prisoners (Haas 2012). The Massachusetts parole board was composed primarily of individuals from law enforcement backgrounds with a limited number of individuals from social work, psychiatry or psychology.

⁹ According to an external report, the Massachusetts state prison population had faster growth than the nation as a whole, growing 3.2 percent on average during the past five years while the nationwide state prison population grew at a rate of 1.7% per year (Ware, Austin, and Ocker 2009).

There were simply not enough facilities to house and contain the population of incarcerated women. At MCI-Framingham, the sole state prison for women, the gym was temporarily converted to hold rows of bunk beds, until the makeshift mutated into the norm.

Yet the link between drug use and the crimes committed by women is an association that demands anthropological analysis. What are the values and cultural orientations that buttress these faceless statistics of largely poor and minority women incarcerated women for drug-related offenses? How exactly, and in what specific ways, is women's drug use made criminal? When my medical school classmates at Harvard traded or popped each other's benzodiazepines or stimulants in order to self-medicate the anxieties of becoming a doctor, they certainly were not sent to drug treatment or prison. In fact, the treatment of "impaired physicians" and "impaired nurses"—for whom drug addiction is seen as a form of occupational hazard—is very different from the treatment of poor drug users.¹⁰

Research on addiction among physicians has shown that workplace stress, relationship difficulties and subjective distress, including attacks on self-esteem and one's personality, contribute to consumption of easily obtained psychoactive drugs/medications (Brooke 1996). There are significant risks posed to the individual as well as to the community's "public safety" (usually a euphemism for crime in the context of drug use) by physicians' drug use; as Matthew Holtman lays out, "Risks to the general population associated with physician drug abuse include malpractice, preventable medical accidents, financial crime, and irregular prescribing practices" (2007: 543). State medical societies in the 1970s lobbied for legislating a therapeutic approach to the drug addiction of physicians "making it less public, less punitive, and more therapeutic," arguing that the impaired physician programs they offered were "less expensive and more

¹⁰ One study in Switzerland found that psychoactive drug use among medical doctors was higher than the general population (Domenighetti et al. 1991).

effective than criminal sanctions”; the so-called “sick doctor” statute allowed physicians who voluntarily entered drug treatment to avoid criminal sanctions and mapped out a path for regaining one’s medical license back (Holman 2007: 544). Using close surveillance, these programs require counseling, group therapy and urine testing for typically a period of five years before restoration of a limited license. In a review of treatment outcomes of 904 physicians engaged in impaired physician health programs, McLellan et al. (2008) found that at five-year follow-up, 78.6% physicians were licensed and working, 10.8% had their licenses revoked and the rest had retired, died or were lost to follow up.¹¹ These outcomes are dramatically better than treatment rates for the general public that “have consistently shown poor compliance rates during treatment, and relapse rates of 40-60% within six months of completing treatment” (McLellan et al. 2008:2).

The drug use of physicians belies the notion that people with drug addiction are not useful and cannot make valuable contributions to society. It also is testament to the success of programs of rehabilitation that do not involve the prison. Medical historian Howard Markel recently chronicled the lives of two famous physician cocaine addicts, Dr. Sigmund Freud and Dr. William Halsted (a famous surgeon at Johns Hopkins who pioneered “science-based surgery” and is considered one of the founders of the modern surgical field). Halstead, who was treated for his cocaine addiction with daily morphine injections at Butler Hospital in Providence, Rhode Island, became addicted to morphine for the next four decades of his life.¹² Halsted was “a remarkably high-performing addict for almost four decades” for whom “intoxication injections

¹¹ These programs are not providing direct treatment; according to McLellan et al., they provide “evaluation and diagnosis, develop a contract detailing treatment or monitoring, coordinate and facilitate formal treatment and ongoing professional support, and carry out regular monitoring through random visits to places of work and regular screenings for alcohol and drugs—typically for five years” (2008: 1). The actual treatment costs range between \$5000 to \$40,000 a year.

¹² William Osler, another seminal figure in medical history, wrote of Halsted: “He had never been able to reduce the amount to less than three grains daily,” which, as Markel notes, was approximately 195 milligrams of morphine (a typical surgical dose is 5 to 20 mg every four hours) (2012: 211-212).

of morphine (and, less frequently, cocaine) loomed far more important to his sense of well-being than all of his surgical accomplishments, medical titles, accolades, scientific papers, students, patients, and considerations of personal health and professional reputation combined” (Markel 2011: 243; 212).

The contributions that Halsted made to the medical field and beyond were truly significant even as he struggled mightily with addiction. Are we not all Halsteds, with the potential for extraordinary output, contributing to the positive development of our communities and relationships, even in the face of (or despite) drug use? How are some lives deemed worth saving, with interventions and treatments of vastly disparate quality and quantity depending on one’s means and social network? Many poor women on drugs strive mightily for “health” and recovery from addiction, often unable to entirely shake the sense of tenuousness of the process of trying getting well.

Recovery From What?

Recovery is an elusive yet powerful notion in not only addiction circles but within mainstream culture as well. Recovery is perhaps one of the most salient tropes of our day, used in a wide variety of contexts within everyday life that are economic, health-related, legal and monetary. “Recovery,” according to the *Oxford English Dictionary*, stems from the late 14th-century Anglo-Norman word *recoverie*, meaning the “action of regaining as a result of a legal process or judgment, legal remedy.” Recovery also quickly came to also refer to “the restoration of a person (or more rarely, a thing) to a healthy or normal condition, or to consciousness” and “the cure or healing of an illness, wound, etc.” It could also refer to “regaining... one’s mental

state” as well as a “restoration or return to a higher or better (esp. spiritual) state.”¹³ Recovery was an endpoint but also the process; it was more than just a material and physical state but also had a spiritual component. As the former Commissioner of the Massachusetts Department of Public Health, John Auerbach, said on “Recovery Day” at the Boston Statehouse in 2012, “The best part about Recovery Day is what it says about the capacity of human beings to recover.” It spoke to one’s potential and one’s ability to be different, better, stronger, healthier.¹⁴

Auerbach implies that recovery is a compelling concept because of what it says about the human condition. Yet recovery is an uneven slope in which the poor and the marginalized often have to work harder with fewer resources to obtain in their lives what some people consider recovery. To think about ‘recovery’ one also needs to seriously examine what epistemological orientations lie behind treatment and what “treatment” actually looks like. What kind of person does drug treatment seek to produce? Nancy Campbell has argued that “treatment is a set of regulatory practices that attempts to bring individuals into conformity with the state’s ideals of the productive citizen. Its success is measured by the compliance and social adjustment of its subjects” (Campbell and Ettorre 2011:56). Is drug treatment a form of social control, of molding and de-fanging the dangerous, poor class into a compliant, non-threatening group? Is it a non-profit industrial complex that benefits off the endlessness and recurrence of addiction, increasingly accepted to be a relapsing and remitting disease? Or is it a genuine way in which

¹³ As T. Bedford wrote in “Sinne unto Death” in 1621: “It shall be lawfull sometime to determine, whether he that falleth, fall desperately, or whether there be any place for recouery” (OED Online 2012).

¹⁴ At “Recovery Day” 2012 at the Massachusetts Statehouse, hundreds of addiction treatment advocates, including troops of people in treatment programs and halfway houses, swarmed into the Gardner Auditorium. An energetic middle-aged black man greeted people with live music, trombone players backing him up: “If you’re excited about recovery, let me hear you sing! Put your hands up! Everybody say, keep coming back! Just keep coming back! Recovery works!” The chorus of the song was catchy: “Higher and higher and higher and higher, ‘til I crash, that’s what gonna happen when you’re getting high.” The crowd and audience join him in singing and clapping ardently as his vocal register climbs and dives with the metaphoric ‘crashing’ associated with using drugs. He gets the crowd to engage in a call-and-response with him about the consequences of not coming back (to treatment): “Jails, institutions or death!” people shout loudly and excitedly as they catch on to the words of the song.

people can attain well-being, better health outcomes, happiness and more rewarding relationships? Can it be all these things at once?

Robert Fairbanks' 2009 ethnographic account of the emergence of some 400-500 addiction recovery houses in a poor, blighted, post-industrial neighborhood of North Philadelphia known as Kensington explores the concept of recovery both as it is used by individuals who live in these houses as well as a site of "poverty management" in the era of neoliberal governance. "Recovery" is a term for the process defining the lives of the entrepreneurial men who inhabit and try to operate these "recovery houses" for profit as well as "an opportunity for self-actualization" (Fairbanks 2009:124). Fairbanks concludes that no one involved in these "recovery houses" actually "recover" in any traditional sense of the word: "What I can say is that the vast majority of recovering subjects that I encountered continued to use substances with disproportionately devastating effects (homelessness, prostitution, incarceration, untimely death). And I can say that these relapses were often borne out of the travails of persistent poverty, suggesting an overall outcome contiguous with longstanding strategies of warehousing as opposed to the actual transformation of selves" (Fairbanks 2009: 177). Interestingly, the government tacitly supports these recovery houses as sites of population management because there are just no other places for these kinds of people to live (planes full of ex-drug addicts arrive fresh from Puerto Rico and buses of men released from jails in New Jersey arrive at these recovery houses).

Recovery in the addictions and mental health field has very specific orientations to the self, to individual and cultural expectations of illness, and to notions of control and autonomy over one's own well-being. As Janis Jenkins and Elizabeth Carpenter-Song point out in their work on schizophrenia, a shift to "improvement without cure" is a new paradigm of recovery in

mental illness (and increasingly addiction) in which the level of desired wellness cannot be achieved without significant personal costs and “work.” Foregrounding “recovery as process and recovery as outcome” (2005:384) they conclude that recovery from schizophrenia is slow, incremental process that involves taking medications but also “sustained effort ... inexorably linked to social engagement” (2005: 390). An individual who obtains “recovery” must exert control of one’s illness/oneself not only by appropriately consuming psychopharmaceutical medications but also by engaging in the hard work of everyday life that equally contributes to one’s sense of wellness.

And unlike mental illness, many view taking drugs to recover from addiction as intensely problematic. When heroin is concerned, the ‘drugs’ of recovery that have been approved by the government for heroin treatment are methadone as well as a newer drug, buprenorphine-naloxone, as well as a “new” old drug, naltrexone. Historically, heroin itself was branded as a cure for coughing by Bayer. As consuming medications and taking drugs and substances into one’s body to achieve a variety of effects—recovery from illness, sleep, performance, bliss, relaxation, enlightenment, new ways to experience sensation—becomes increasingly the cultural norm, how does such mass consumption affect our relationships to ourselves and others? Janis Jenkins wonders how such drug-taking relates to social inequality and structural violence: “Do such drugs alleviate personal and social suffering that is otherwise overwhelming, or do they merely mask and dislocate the source of such suffering and impeded personal and institutional action that could more broadly transform disordered social and biological conditions” (2010: 4)?

The study of the inner lives and experiences of addicted women has the potential to highlight ongoing patterns of oppression and subjection imposed by carceral regimes. It is a way to see how individuals can become “the conflicted site for moral acts and gestures amid

impossibly immoral societies and institutions” (Biehl, Good and Kleinman 2007:14), where subjectivity bridges the inner processes and the rich mental life of individuals with modes of governance and forms of subjugation.

Taking pills and consuming substances alters the fabric and texture of this everyday experience. But how do people’s sense of selves change under addiction and criminalization? I argue that what distinguishes the experiences, stances and moral processes of people who use so-called “hard” drugs from others who take pharmaceutically produced pills and drugs is the heavily criminalized imaginary of the street. These lines between “licit” and “illicit” actually are at the very heart of our social assemblage, as we increasingly seek to define and stratify our relationships to each other along perceptions of safety, risk and community. Attendant to the production of social difference are differential levels of risk, danger and violence that inform one’s inward and outward stances towards the world, depending on one’s proximity to the so-called “street.”

Anne Lovell’s (2006) work on the history of buprenorphine in France makes explicit the linkages between the market of legal psychopharmaceutical addiction medications (such as buprenorphine and methadone) to the street markets of heroin and other illicit drugs. She notes how the opiate-containing medication itself transfigures into vastly different kinds of things—gifts, objects of desire or danger, commodities, to name a few—as it passes from the clinic to the street. Critically, for Lovell, the experience of drug addiction is inextricably bound up with attempts at self-care as French opiate addicts seek to obtain, use and sell buprenorphine for and with each other.

Allison Schlosser and Lee Hoffer’s work on subjectivities individuals with co-occurring disorders (addiction and mental illness) also demonstrates the increasingly blurred lines between

experiencing the licit and illicit, what they call “good” and “bad” drugs. Using the narrative of one of their participants, Susan, a 34-year old white woman who describes herself as a heroin addict with diagnoses of bipolar disorder and PTSD, they describe how when Susan was taking psychiatric medications “as directed,” she stopped using street heroin, but she gained over a hundred and twenty pounds and felt “alienated from what she considered her “true,” “normal” self” (Schlosser and Hoffer 2012: 35). She went back to heroin shortly thereafter: “She viewed heroin as an alternative means to self-treat her anxiety, dispelling her need for Valium as an anxiolytic. Heroin, in effect, met multiple needs simultaneously” (Schlosser and Hoffer 2012:36).

Furthermore, for individuals who are involved in the “institutional circuit” (Lurhmann 2008) their access to prescription medications is insecure while there is a flush availability of the same medications on the street. Women like Susan are actively managing both their addiction and mental health issues by creating and concocting bodily sensations of “normalcy” and seeking out specific physical effects, re-asserting agency in the face of social suffering and structural violence.

But such habits of consumption should be viewed within the political economy of pharmaceuticals within what Merrill Singers calls the “War For Drugs” (2008: ix). In *Drugging the Poor*, he posits that the unabated levels of addiction and suffering of the *lumpenproletariat* fuels capitalist profit and creates new economies intended to manage poverty and suffering:

By examining (1) the diverse parallels and direct connections between the tobacco, alcohol, pharmaceutical, and illicit drug industries as variously intertwined expressions of global capitalism and (2) the tendency of the poor and oppressed to use and mix the commodities produced, widely distributed, and heavily promoted by these industries to self-medicate the psychological and emotional injuries of inequality, (3) it becomes clear how multibillion dollar corporations and their exceedingly wealthy executive decision makers play a profound role in shaping the lives of the poor and the social and health conditions the endure (2008: 235).

Singer, unlike Lovell, does not just argue that the legal and the illegal markets work in tandem; he goes one step further and argues that the legal market actually knowingly profits off the “non-recovery” of the poor and their attempts at self-medicalization of the conditions posed by their poverty. For Singer, the promotion of illegal drug use “contributes to maintaining an unjust structure of social and economic relations” (2008: 230) by maintaining a cheap laboring class and also quelling rebelliousness and resentment of exploitative conditions. His critique calls into question *what licit and illicit drugs are meant to actually do*; how do drugs fit into literal and moral economies of health and well-being, possibly at the elision of more troubling and deeply rooted social determinants of health?

These new economies of poverty and addiction management can also affect the sense of temporality in drug users’ lives. As Angela Garcia observes in her work on heroin addicts in rural New Mexico, there are unintended consequences to recasting addiction as a chronic, relapsing and remitting disease in well-meaning attempts to diminish the stigma of drug addiction. In the Espanola Valley, Hispano locals view heroin addiction as an escape from lives of melancholy, a sense of hopeless futures, and a history of land dispossession. Contrary to being a vice or an inherent personal weakness, heroin use was “*medicina*”: it allowed a despairing people to feel better, to imagine the possibility of an alternative future (2010: 126). The biomedical and institutional responses to the epidemic of addiction in rural New Mexico are paltry at best or actually damaging. Addicts internalize the failures of the medico-legal treatments as their own fault. They become “imprisoned” by discourses of personal responsibility and self-control; as Garcia observes, “Institutional structures and claims are absorbed by the addict, exacerbating a sense of personal failure that contributes to a collective hopelessness” (2010:8-9).

The Criminalization of Women on Drugs

Women in Massachusetts who are addicted to heroin and burdened by not only by their failures to get clean, but by the stigma of incarceration and the enduring social effects of having been incarcerated. But only some women who use drugs get sent to prison. And not all women who use heroin necessarily commit crimes or go to jail and not all women who end up in jail are necessarily “guilty.” A human rights lawyer and writer pair, Robin Levi and Ayelet Waldman, attribute the dramatic growth in number of incarcerated women to “mandatory minimum sentencing for drug crimes which preclude judicial discretion, the dismantling of the U.S. mental health system, and increased prosecution of “survival” crimes, which include check forgery and minor embezzlement” as well as “offenses that arise from drug addiction or mental health problems, or as a result of minor involvement in offenses perpetrated by their husbands or boyfriends” (2011:18).

Historian Nancy Campbell writes that the link between women’s drug use, crime and subsequent incarceration is still (surprisingly, perhaps) not that clearly elucidated because of disciplinary boundaries: “Criminology—whether concerned with studying males or females, adults or adolescent—has been especially prone to ignoring drug use as a topic... criminology explained women’s crimes—shoplifting, prostitution, or “sexual ungovernability”—as the outcome of biology or emotion” (2000: 217). A more popular version of the women-drugs-crime linkage now tends to go like this: women grow up in low-resource households with lack of economic or educational opportunities, develop dysfunctional, abusive relationships with men, experience trauma, turn to substance use as self-medication, and then turn to crimes of economic

“survival” or crimes related to enacting violence upon abusers (Bloom, Owen, and Covington 2003).

Law professor Jody Raphael uses one woman’s story, Tammy, to try to illustrate these linkages: “For Tammy, using heroin was a method to exert power over her environment, an active way for her to seize the initiative, to reduce the anger, and to wipe away feelings of self-hatred” (2007:135-136). She continues, making the leap to trying to explain Tammy’s crime of stashing drugs at her house for a friend to make money to support her husband’s drug addiction: “Experiencing anger and aggression from the loss of power and self-esteem through drugs, the women search for a sense of empowerment through drugs, and they try to cope with the effects of being trapped in abusive and dysfunctional relationships. In these circumstances, the drugs, the relationships, and the numbing of the self lead to even more self-destructive and antisocial acts” (2007: 138).

Americans are fascinated with crime and criminality, especially the crimes of women, with entire television channels devoted to courtroom drama, police shows, and even “documentary” and drama-based shows about life in prison. It is not a uniquely American affliction but our consumption of such media has little to do with increasing our understanding about a vast, largely dysfunctional system that ensnares poor women. Partly fueled by voyeurism about the “badness” of others, we are intrigued by what lands women in prison. What have they done? Even well-meaning, left-leaning primary care doctors want to know. What was the crime?

Part of the desire to know the crime is to imagine that crime is a way to access another’s deep interiority, a way to peer deeply into someone’s soul. But for women, their “crimes” are not part of an unchanging essence; rather, they are situations and stories particular to a specific place and time and person. For the women I came to know, some well and others just through

interviews, their “crimes” were long, complicated stories that took five, ten, twenty minutes, an hour to explain. To understand the alleged crime, you had to understand that the relationship was bad from the start, how they had met, why he hit her and how often, and you had to understand the amount of drugs they both were on, you had to understand how much the baby cried and how sad it was see him without clean diapers, you had to understand that she desperately wanted to be a good mother, she needed those diapers. Or you had to understand the complex relationship between mother and daughter, and how they oscillated between love and hate, and how the mother used her daughter’s addiction to punish her under the auspices of care, and that the prosecutor wouldn’t drop the charges even though the mother tried to drop them.

I found myself getting involved in these narratives of crime. Nothing about the “crimes” of the women I came to know was straightforward nor was the arduous, byzantine process of criminal justice proceedings that followed said crimes. I learned how a charge of “breaking and entering” meant squatting in an abandoned house to avoid homelessness in one of Boston’s harsh winters. I learned how being disorderly at a concert while high on drugs could become a charge of assaulting and battering a cop, a violent felony. While women freely admitted to behaving badly, the criminal charges they faced were often ratcheted up to the next level, to a stronger charge with a larger punishment.

Their current charges were often one of many, each with its own story, its own unique constellation of events and actors. Their lives were not defined by graduating high school or getting a college degree or getting a promotion, rather their lives were defined by when I got that prostitution charge, when I got arrested for check fraud, when I first did significant [prison] time. These “narratives of crime” are a specific kind of relation to the self in which women frame themselves and their actions in relation to a complex world where decision are largely made in

half an instant, driven by affect. And while I am not advocating that things these women have done are excusable or do not cause harm, there must be another way to think about drugs and crime.

For example, Jane, a recovering heroin addict struggling with several months of clean time while on suboxone therapy, shoplifts chronically from Walgreens because she sees things she wants for her child and feels that she is too poor to pay for it, plus, she has largely gotten away with it the past twenty times she has done so. Her bathtub is full of the shampoos and conditioners that she has shoplifted. The thin bathtub shelf overflows with forty or more shiny plastic bottles promising some kind of beauty. The fact that she has been arrested for shoplifting before and has bench warrants out in two local districts for not paying her court fees and/or doing the mandated community service means that she very well could go to jail if caught shoplifting again. She also can't get her license renewed because of the warrants, so she can't look for work and she can't pick up her own prescriptions at the pharmacy for her suboxone.

But she continues to shoplift, against the odds. At one point, I tried vainly to convince her that shoplifting puts her at risk of being separated from her children if she had to go to prison (she had never been incarcerated before). But she does not stop, because she longs to feel like a provider for her son. If she cannot be a consumer of the latest expensive toys, and she truly feels "unable" to afford them, she is not a good mother, and these feelings must be reckoned with. These emotions are critical for understanding moral experience; as Tanya Lurhmann argues, summarizing Catherine Lutz's work with the Ifaluk, "Emotions are our most basic moral reactions... the way we make fundamental judgments on the rightness or wrongs of social acts" (2006: 355).

The emotional life of incarcerated women with histories of addiction is complex, often clouded by shame, regret and internalized social stigma of being a woman in prison.¹⁵ And no one woman has the same life circumstances or stakes. This became clear when we talked about drug use during pregnancy: some women adamantly refused to do anything, desperately seeking treatment or becoming abstinent as soon as they knew, while others felt that they just could not stop injecting heroin, even if they appraised the same risks to the baby. Why would one woman run from parole (not show up until she gets caught and re-incarcerated) and another show up religiously, afraid of having to go back to jail?

Yet for all their differences, one common denominator for these women is their health: their lives are more likely to be cut short than women in the general population. A study by sociologists at Suffolk University showed that among a group of 839 female drug users that were followed after incarceration at MCI-Framingham prison, over 11% of the sample had died at fifteen years follow-up, and of the 90 women who had died, the median age was 44 years old (Sered and Norton-Hawk 2011). The riskiest time for overdose is when someone has lost physiological tolerance, often after prison, jail or short periods of treatment. Staton, Leukefeld and Logan (2001) found that resumed drug use was the most common reason for not getting regular check-ups among women leaving prison. Ingrid Binswanger and her colleagues (2007) have shown that individuals leaving prison in Washington State have a 12.7 times greater risk of death than the general population; the adjusted relative risk of death among former inmates was significantly higher for women than for men. Why do women leaving prison have a higher risk of death and injury than men?

¹⁵ Alfreda Robinson-Dawkins writes of her incarceration and subsequent release: "Forgiveness. Do people forgive you once you have been incarcerated? Do church people forgive you? Do people feel uncomfortable around me once they know I served time in prison? Do they think I can act sociably and civilized after being treated like an animal for so long?" (Solinger et al. 2010: 374).

The communities to which women return to from prison—often their home communities, but sometimes new ones—pose many risks and dangers for women. This is partly the reason that some women conceive of incarceration as “saving” them from their own actions in these spaces. The fact that there is no place that is “safe” for them but a prison illustrates how marginalized these women are from mainstream social services as well as the general weakness of the social safety net. It reflects poorly on the shelter systems and detox programs, where women routinely report their possessions stolen or even report sexual abuse.¹⁶ The sociologist Megan Comfort laments the “paradoxical effects that transpire when the criminal justice system becomes the most powerful social institution consistently available to poor Americans and by default assumes myriad functions previously handled by the social wing of the state” (2007: 273).¹⁷

In this dissertation, I explore the moral experiences of women who are subjected to everyday violence, oppression and inequality from many realms: within themselves, within the judicial system, within their relationships, within their communities (Scheper-Hughes and Bourgois 2003). I follow them as they seek treatment in the community, as they try to care for themselves in the prison and after the prison, as they cycle in and out of various regimes of care. I am interested in how they come to grips with their pasts and envision their futures within the context of forced exile, un-belonging and unfreedom—the temporary banishment of incarceration—and their subsequent “re-entry” into a limited form of citizenship that being incarceration confers. I found that women on heroin struggled mightily with the “dilemmas of freedom” (Valverde 1998) that addiction, addiction recovery and incarceration posed as they

¹⁶ For example, in 2005 an employee of the Dimock women’s detox facility in Roxbury was accused of and arraigned for raping a woman seeking recovery from crack cocaine addiction in a bathroom at the clinic (Fargen 2005).

¹⁷ For many women, it is the only time to get a check-up. One time at Cook County Jail, I saw patients in the sexually transmitted disease clinic with the doctor. The African-American patient, middle-aged and weary, greeted the white female doctor effusively: “Doctor! You did my pre-natal for both my kids: they’re 17 and 10 now!”

navigated various biochemical, spiritual and socially prescribed forms of dependence and freedom.

This dissertation takes readers through various domains and conceptions of the “treatment” of women on heroin. It primarily focuses on the “treatment” in prisons and jails but at times reflects fieldwork I conducted in a community suboxone clinic to provide contrast. Here I explore epistemological orientations to the treatment of women with heroin addiction, the process and actualization of treatment and how participating or experiencing this treatment impacts women, their sense of selves and their abilities to enact healthy, happy and fulfilling lives. What does life after treatment and/or incarceration look like?

I first explore in Chapter 2 the local politics of treatment, recovery and incarceration as they affect women in this study. I use the notion of “bad habits” to think through engrained and embodied ways of being-in-the-world as well as a space of governing individual behavior. In Chapter 3, I examine the historical origins of the incarceration of women and notions of rehabilitation of women on drugs. Why did the prison become a central node in addressing the social problem of drug use and addiction? In Chapter 4, I examine contemporary approaches to drug addiction in both the state women’s prison and the Boston jail. How does drug treatment—a mandate to cure—align with the prison’s primary orientation towards security and punishment? In what ways are rehabilitation and well-being imagined by prison drug treatment and mental health workers? In Chapter 5, I examine how illicit drugs make their way into the prison, disrupting both drug treatment and the prison’s public image as a secure facility. I examine how pharmaceutical companies fuel illicit opioid use and increasingly blur the line between ‘licit’/‘illicit’ drug use. Poor women on drugs in the prison system are pathologized, their

problems elided into treatable mental health conditions, and they are heavily targeted as consumers of psychopharmaceutical cures.

In Chapter 6, I examine the space of trauma treatment in the prisons and jails as the women's prisons turn to notions of 'gender-responsiveness' and seek to become 'trauma-informed' institutions. I argue that the prison makes itself a central actor in the social response to the seemingly endemic trauma of poor women on drugs through the adoption of trauma rhetoric, or "trauma talk." In Chapter 7, I follow one woman's life in detail as she cycles through social institutions that dominate the lives of the poor: prisons and jails, hospitals and shelters. Using Lydia's case, I examine how the prison participates in creating physical risks and social dislocation for women upon their release. Through the lens of social death, I wonder about how the terrain of biopolitical schemes condemns some to lives of suffering and death (they are "let die") and why others do not face such risks. Finally, in Chapter 8, I explore the relationship of incarcerated women and women recently incarcerated with recovery and the labor market. I examine the recent attempts by prisons and jails to put women to work after incarceration and how and why their efforts fail because of the blight that fact of incarceration bears to any resume. I conclude by offering new ways in which we imagine and actualize other ways to "treat" women on heroin and other "habit-forming" drugs.

And a note on methods: While I recruited approximately ten women each from three sites, the women's prison (MCI-Framingham and the minimum security, pre-release facility, South Middlesex Correctional Center (SMCC); Suffolk House of Corrections (the main Boston jail); and a suboxone clinic at a public health hospital in Boston, I fluidly move between these sites as I follow individuals through systems of care and various social institutions. It is "person-

centered” rather than “institution-centered.”¹⁸ Some institutions receive more analysis than others as a result of this approach. I found that the women recruited from both the community and the prison had very similar backgrounds and over seven of the ten that I recruited in the community had histories of incarceration, reflecting our social response to opiate addiction. They also often moved between all these spaces: many of them that I met in prison had been hospitalized before at the local hospital and vice versa. There are a boggling number of institutions that women with histories of heroin addiction have interfaced with, and hopefully this work reflects the byzantine number and ways in which these organizations interact.

I approach this work as both a student of anthropology as well as clinical medicine and as an HIV/AIDS activist. While this dissertation reflects these multiple (and sometimes conflicting) identities, I hope that it remains grounded and useful for practitioners and advocates who address this everyday. I dedicate this work to the women who live within these systems of oppression and care. I hope the spirit of their stories is reflected in the following pages.

¹⁸ A note about the groups of women I followed: The community group (n=13) included women ages 23-51, two African-American, the rest Caucasian. Several had polysubstance use in addition to heroin addiction (cocaine). Of the women recruited at MCI-Framingham/SMCC (n=10), one was Hispanic, one was Cape Verdean, one was Greek, one was Portuguese, and the remaining women were Caucasian. Of the women recruited at the Suffolk House of Corrections (n=11), three were African-American and the rest were Caucasian. As a group, the women were largely differentiated by age and first opiate use: all women under 30 years of age had started on prescription opioids leading to heroin use, while all women above 30 had started directly with heroin.

Chapter 2: The Politics of Addiction Treatment and Recovery

Troubling though it might be, the convergence of addiction treatment and the prison is more the norm than the exception in the contemporary United States. Anthropologists Eugene Raikhel and William Garriott argue that we must understand the trajectories, including the directionality, of drug use and drug policy, how addiction “must be seen as a trajectory of experience that traverses the biological and the social, the medical and the legal, the cultural and the political” (2013:8). Few anthropologists of addiction have examined the space of the prison, even though criminalization of drug use has come to define the dominant policy stance towards addiction.

So following the “addiction trajectories” of women on heroin in Massachusetts, we must travel along an increasingly trammled road to the prison and the jail. The prison is one of many central nodes in the increasingly fraught neoliberal politics of addiction treatment and recovery. To understand just how the prison became foregrounded in the problem of drug use and why, it is critical for us to examine the larger political-economic structures that support its centrality.

In Massachusetts, the state is still grappling with a 2012 scandal involving the Massachusetts Department of Public Health (MDPH) Hinton drug lab in Jamaica Plain that exposed the corrupt government “War on Drugs” machinery.¹⁹ Forcing the resignation of the much-beloved MDPH Commissioner, John Auerbach, the scandal centered on the activities of one now-infamous chemist named Annie Dookhan. The 36-year-old chemist had been caught “dry labbing,” that is, looking at a substance (a white powder, for example) as certifying it as

¹⁹ Reporters discovered that in some instances, no name was attached to a test, some cases were labeled “Fat Black Man CB#1,” and the consequences of her findings were often used or prodded for by state prosecutors in order to obtain convictions. The lab itself was in disarray, with drug samples found in garbage cans, drawers, cabinets that were improperly labeled, even drug samples contained in manila folders marked “Quality Checks.” There was little to no standards of care enforced and no compliance checks.

illicit without doing the necessary chemical testing (Coakley 2012). She also had mixed drug samples and processed several thousand more samples than her peers at the lab, with possibly 40,000 affected individuals in criminal cases between 2003 and 2012. In cases related to her “evidence,” people lost their jobs, lost their children, risked deportation or were sent to prison.

The belief that “hard science,” particularly when used in legal contexts, is unbiased and impartial is naive at best, but the Dookhan case exposed the tragic vagaries of a deeply flawed criminal justice system and a failing “War on Drugs” in which people went to prison for possession or trafficking under mandatory sentences based on the amount of a substance. The Attorney General Martha Coakley stated that what was tragic about the situation was not just Dookhan’s actions: “Certainly one of the victims in this case... is the public trust” (Valencia and Ellement 2013).

While state officials rapidly tried to paint Annie Dookhan as an isolated incident in a sea of otherwise upstanding and precise agents of the criminal justice system, it became clear she was connected with prosecutors in unsavory ways. In emails obtained by prosecutors, she “coached assistant district attorneys on trial strategy”; in an exchange with Norfolk County Assistant District Attorney George Papachristos, who later resigned, he told her he needed a marijuana sample of over 50 pounds to get a conviction of drug trafficking (“any help would be greatly appreciated!, he wrote). She wrote back two hours later, “Definitely trafficking, over 80 lbs” (Estes 2012).²⁰

²⁰ The lack of impartiality of the drug lab was not surprising to many observers. The prosecutorial apparatus in this country feeds off the inevitable poverty and lack of means among the people it charges with so-called crimes. It produces statistics within vast bureaucracies that demand accountability and numbers (conviction rates). Poor people are netted in systems in which they cannot make \$50 or \$100 bail, languishing behind bars for months on end. They are forced to take plea deals, which count as convictions, under the threats of prosecutors to give them the maximum sentence unless he or she pleads. Defense attorneys and public defenders have argued that if people refused to take plea bargains, the entire judicial system would be unable to function; 94 percent of state cases and 97% of federal cases are resolved by plea bargaining (New York Times Editorial Board 2012: A24).

Two of the women in my study were affected directly by Annie Dookhan and the Hinton drug lab scandal. One woman, Sarah, a 30-year-old redheaded mother from the South Shore, told me that she had received a letter from a probation officer stating that her case was Annie Dookhan's and that they potentially could take it off her record. She was close to completing two years of probation, and since she was already out in the community, her case was very low-priority. Sarah wanted to get her record cleared completely so she could apply for jobs as a medical assistant with a clean CORI but she sadly remarked, "I'm just not a priority for them."

The second woman, who asked to be called Serenity Davis, was actually incarcerated in the local jail and was involved in a drawn-out series of court appearances when the prosecutor revealed that the state's evidence had been handled by Dookhan. The case was from January of 2012 and it was June 2013 when the case finally came in front of a judge. The charges: drug distribution, class B (cocaine) and drug violation near school/park. The public defender asked for a motion to suppress, since the Commonwealth of Massachusetts had shown no evidence that there was any transaction. The judge, a middle-aged no-nonsense woman, grilled the young female District Attorney, who protested, "We understand the final discovery was requested, and we understand this was a Hinton lab case." The judge, upset, demanded to know why it has taken so long: "That doesn't matter. It's a year and a half later. Where's the discovery?" The district attorney pleaded for one more day. The judge angrily yelled, "Somebody's not doing their job here."

Eventually, the judge dismissed the case against Serenity and she was released from court. But how many months was she kept incarcerated on the bad or non-existent evidence of the state? Over three hundred people were released from prisons and jails after the Dookhan case. The release of so many "convicted" criminals—albeit on faulty evidence—brought fears of

increased “public safety” risks.²¹ Really the Dookhan case just made clear what many people had already suspected: the War on Drugs was a failure, marked by a corrupt, sham system where the deck was stacked against poor people of color. Such “crises” interrupted the usually non-transparent “business as usual” by highlighting the structural forces that collude with individual behavior.

Erosion of Public Addiction Treatment Programs

At the same time, there was a different kind of war, a subtle and less visible war won by diminishment and flat-funding, a largely invisible wearing down of political and financial commitments to comprehensively treating addiction. In March 2012, there was surprise news that shocked the Boston drug treatment scene. Partners Healthcare (the combined healthcare groups of Massachusetts General Hospital and Brigham and Women’s Hospital) announced they were closing the BWH-owned Faulkner Hospital inpatient detox unit, widely considered one of the most well-run and expertly staffed detox facilities in the greater Boston area. Closing the unit meant that Boston would lose over half of its Level 4 (medically complicated detox) beds.

The Massachusetts Department of Public Health’s Bureau of Health Safety and Quality hastily organized a forum about if the discontinuation of the addiction treatment unit would compromise “access in health status” for residents. If it was determined this was the case, the state would order the service to remain open and the hospital could re-petition. At the standing-room only public forum, Partners leadership presented the rationale for the plan. They argued in favor of closing 15 dedicated substance use treatment beds with six medical-surgical beds:

²¹ When a man released to Brockton as a part of the Dookhan case killed another man, fears were confirmed. Yet not everyone saw it as the fault of individuals. “I don’t think the drug lab is a problem at all. I hope they all get out. Rather than focus on the drug lab, which is the lowest hanging fruit, we need to focus on this unjust war on drugs. Why not focus on preventing and solving serious crimes in this community?” Reverend Michael Walker of the Messiah Baptist Church in Brockton told a WBUR reporter (Becker 2013).

“BWH Faulkner has developed a plan to transform our current addiction recovery program by replacing our inpatient unit with expanded and modernized set of other inpatient and outpatient services with other capabilities.”²²

A long litany of Boston politicians spoke against the Partners plan.²³ Representative Liz Malia, from Jamaica Plain, publicly in recovery from alcohol for many years, argued that the legislature had never released the amount of funds necessary to prevent substance-related deaths and that the number of lives that the Faulkner had saved or changed was incalculable.

Representatives from South Boston and Dorchester argued that cutting 15 of the 140 Level 4 beds in the state, and 15 of the 35 total beds in Boston, would be too detrimental for a state in the middle of an “opioid epidemic,” resulting “in increased pressure on our emergency rooms and overcrowding of lower level units where they would not receive the current level of care they currently receive... Lives would be on the line.”

Patients, staff and supporters of the Addiction Unit at the Faulkner roundly rallied against the Partners’ representatives. Nurses who had worked on the unit for decades noted their specialized approach based on “the recovery model” based on providing a specific milieu therapy. They argued, “Transforming 7-South to a medical model with untrained staff does not

²² They claimed the unit never functioned at full capacity (“indeed, the average daily census on our unit remains 8 or 9 patients since 2005”). They broke down the patients into two populations: 55% alcohol-related and 40-45% opioid-related diagnoses. The plan was to move the alcoholic patient type to six specified “medical-surgical” meds with addiction faculty that would round on them. The plan for the opioid-related diagnoses was to move them to an outpatient suboxone detox with a therapeutic group component (since “withdrawal is less physiologically risky and can now be managed by a more gradual ambulatory weaning or maintenance with use of the medication suboxone”). They implied that adverse events regarding patient safety had occurred on the addiction unit due to the lack of medical oversight.

²³ Mayor Thomas Menino wrote a letter against the plan, stating, “I cannot support at this time the elimination of the 14 beds, inpatient Level 4 substance abuse unit beds, without a guarantee that the same number of beds will be reserved for eligible patients on the general medicine floor.” Senator John Keenan argued that such changes would not benefit many patients suffering from addiction, a unique disease demanding a unique treatment that the addiction unit provided, milieu therapy. He noted that it would also put pressure on the Worcester Level 4 beds, and he felt like patients would just not tolerate having to travel to Worcester for addiction care. He worried that “they will end up boarding in emergency departments [in Boston].”

address the seriousness this disease presents.”²⁴ Eventually they argued that it was actually about the bottom line, since Faulkner could charge insurance more for six medical-surgical beds than for the fifteen addiction-specific beds: “Partners made \$352 million in profit last year. Where are their priorities? Let’s save lives!”

One of the 7-South staff noted that the addiction unit also taught fellows, residents and medical students in the unique care of patients with addiction; that service would disappear with the unit. A representative from one of the Massachusetts nurses’ union argued that this action represented part of the War on the Poor and that nurses were some of the most affected: “Nurses report that emergency rooms have become dumping grounds from our police and fire departments for those suffering from drug and alcohol abuse who are left out on the street for lack of treatment beds, homeless shelters, and other services to keep them out of harm’s way.” This would only worsen the statistic that Boston had the highest rate of emergency department visits among 11 major metropolitan areas across the country for substance use.²⁵

There was a strong representation from the Graduate Group at the Faulkner Hospital that was a mainstay of the addiction treatment program there. They felt that the program had saved their lives. Many of them had been meeting regularly each week for years to support each other with principles they cultivated together on the inpatient unit. They argued for the sake of their lives, their health and for others out there like them. Kitty Dukakis, the former governor Michael Dukakis’ wife, sent a letter with her niece who had struggled with addiction and had gotten clean

²⁴ They noted that when they told the administration that when they needed more resources to treat patients in 15-beds, the administration responded by capping the patient census at ten (“to falsely represent that as a lack of need is disingenuous at best”). Medical colleagues “don’t understand the nature of the milieu, of the specific therapeutic environment, and a hospital bed and a social worker and a doctor who makes rounds once a day is not a therapeutic milieu.”

²⁵ According to a December 2011 report published by the Substance Abuse Mental Health Services Administration (Substance Abuse and Mental Health Services Administration 2011b), the greater Boston area had the highest rate of emergency room visits for illicit drugs in 2009 (571 per 100,000 people), compared to New York (555 per 100,000), Chicago (507 per 100,00) and Detroit (462 per 100,000).

in the 7-South unit. The letter detailed how Kitty Dukakis scrambled to find treatment for her niece: “She said that when her niece called her urgently for help one day, she struggled to find an available bed, and she pitied those ‘who didn’t have a former first lady of the Commonwealth to go to bat for them’” (Wen 2013). Ultimately, the Department of Public Health ruled that the hospital had to stay open and answer to charges of limiting health access. But it was only a temporary stay of execution.²⁶

Drug treatment tends to be viewed bleakly from a policy perspective. As drug treatment researchers lay out the problem: “Unfortunately, a focus on treatment as a single-episode intervention is one that politicians, policy makers, and the public commonly hold when assessing the overall value of drug treatment. Too often, the conclusion is that drug users are unredeemable, rather than the policy attention needs to focus on improving treatment in ways that realistically address drug dependence as a chronic condition” (Anglin et al. 2001:19). So a population viewed as recalcitrant and unredeemable faces difficulty garnering political or popular support, even if \$1 spent on treatment would save \$2 to \$6 dollars, as a report by NIDA (2010) suggested.²⁷

²⁶ It was hard to find a reason other than the bottom line that Partners would close one of the best, most-skilled addiction treatment units in the region. Any heroin addict who heard about the hospital’s plan to use outpatient suboxone to detox a patient from heroin would be immediately suspicious. What would guarantee that a patient would comply voluntarily with treatment while living at his or her home, shelter, sober house, etc? The entire point of hospitalization was a dedicated and healing environment in which one’s symptoms could be safely, knowledgeably and humanely addressed. How could that happen in an outpatient setting?

Jane, one of the women in my study, a mother of two from Everett whose boyfriend was in prison, called me once after she relapsed to heroin when she let a drug dealer stay in her apartment. He had dropped a “finger” (7-10 grams of heroin, a very large quantity) in her apartment and she proceeded to spend the whole week using it all. Of course she did not emerge unscathed after that week: she had acquired a vicious habit. She called me at 7am, desperate to get into a detoxification program. I told her to call the Faulkner, the best treatment center in town. She went to Faulkner later that day and credits Faulkner with helping her recover from her relapse. She could slowly cobble her life back together, resuming her suboxone maintenance therapy upon her release from the Faulkner program.

²⁷ Funding for HIV treatment, closely linked to substance use, was also cut that year. In 2012, federal cuts led to the elimination of \$1.25 million for HIV testing and education in local Houses of Corrections across the state, leading to the loss of dedicated staff to test, treat and counsel high-risk individuals at local jails (Cramer 2012).

Treatment was shutting down even though Massachusetts was experiencing what epidemiologists had called an “epidemic” of overdose-related fatalities.²⁸ According to *Common Health For the Commonwealth*, a report published on rates of preventable conditions and diseases in the state of Massachusetts, “Entire communities are struggling with the public health and public safety effects of what many experts are calling an “epidemic” of substance abuse” (Massachusetts Health Council 2012: 50). Of concern to the commission was that heroin admissions exceeded alcohol among the 100,556 adult admissions in the state for substance use treatment in 2011 (2012: 51). The Massachusetts Oxycontin and Heroin Commission in their 2009 report also concurred about this “epidemic.” They wrote in the introduction to their report:

Between 2002 and 2007 the Commonwealth lost 78 soldiers in Afghanistan and Iraq. In the same time period, 3,265 Massachusetts residents died of opiate-related overdoses. The Commonwealth is long men and women on its streets at a rate of 42 to 1 compared to what the state is losing in two wars overseas. Addiction is a medical disorder, and we have a public health epidemic on our hands that is larger than the flu pandemic. If the H1N1 virus killed 3,000 people in a five-year period in Massachusetts, the crisis would be center stage and the entire Commonwealth would be working to find a solution to protect the public. However, because of the stigma surrounding substance abuse the opiate epidemic is left in the shadows and little light has been put upon reforming the policies involving substance abuse in the Commonwealth (2009:5).

The Commission felt that addiction posed a “tremendous burden on state and local governments, courts, corrections and hospitals... the state paid almost \$200 million in emergency room costs related to overdoses in 2005, the Massachusetts Department of Corrections is at 143 occupancy, and the Bureau of Substance Abuse Services, MassHealth and the uncompensated care pool account for more than 75 percent of the dollars spent on substance abuse services in the Commonwealth” (2009:12). They were critical about the 2% of money that Massachusetts spent on prevention, treatment and substance use research: “For every \$100 the

²⁸ Opioid-related mortality is a significant but relatively small cause of death in America but the shadow it casts is long and unseemly. In the United States, the use of cigarettes contributes to one in five deaths—approximately 480,000 deaths a year (Centers for Disease Control 2014). In 2010, 25,692 people died of alcohol-related causes (not including motor vehicle accidents or other indirectly related deaths) and 40,393 people died of drug-related causes (Centers for Disease Control 2013c; Mack 2013).

state spends on substance abuse and addiction, only \$1.45 goes towards prevention, treatment and research” (2009:15). A total of \$1.084 billion was spent on “substance abuse and addiction in the justice system”—largely to incarcerate people with drug-related criminal convictions—approximately at 5.3% of the total state budget” (2009: 18); \$810 million of that expense went to the Department of Corrections to incarcerate approximately 150,000 people.

They noted that state spending on the prison system was the “fastest growing or second fastest growing item in state budgets over the last fifteen years” (2009: 40). In Massachusetts in FY2009, *the corrections budget surpassed the budget for higher education* and even though the prison costs increased, recidivism rates remained largely the same—to use Angela Davis’ words, the prisons were “siphoning social wealth away from such institutions as schools and hospitals” (Davis and Dent 2001:1238). At the same time, the Bureau of Substance Abuse Services’ budget was cut \$16 million in 2001-2004 as the Department of Public Health’s budget was cut. As a result, the public detox system shrank significantly: six of twenty-two public detox programs closed down, five residential recovery programs that had provided 250 treatment beds closed down, and acute service emergency beds plummeted from 997 to 420 (Na’im and Greenberg 2004:25). Uncoordinated state bureaucracies were largely indifferent to the budget lines of other agencies.

At a forum on addiction policy sponsored by the Massachusetts Organization for Addiction Recovery (MOAR), a young Hispanic man from a halfway house stands up at the end of a two-hour long policy presentation on the state of drug treatment and prevention programs in Massachusetts. He asks a question in that semi-deferential, yet blunt manner that marks a

straight-talking drug addict in a room full of suits, all of whom are talking about the need for more money for addiction treatment, for more treatment beds, for a wider variety of programs.

“I just have a question,” he says. “It doesn’t make sense to me. Massachusetts has the most programs but Massachusetts has the most overdoses... Is more programs necessary or are better programs better than more programs?” He couches it deferentially, I’m just a drug addict.

But he is really cutting to the core of the issue at the heart of Massachusetts’ drug problem—namely, that Massachusetts ranks sixth highest in the country in terms of the drug treatment it provides but the state continues to be plagued with thousands of opioid-related fatalities a year. Boston is one epicenter in the state that represents a subtly shifting War on Drugs story that now starts with white middle-class youth doing prescription opioids and eventually moving to heroin that is cheaper, stronger and faster. Massachusetts has a unique, somewhat responsive political landscape in which addiction and mental health have substantial advocacy groups and legislators discuss the problem of addiction candidly.²⁹

But the landscape of public and community systems of addiction care and their relationship to prison-based treatment is complex. Drug treatment programs in the prison and the community are intrinsically interwoven and share many common orientations and discourses. There is an astounding array of organizations, groups and institutions that claim to do the work of drug treatment. Ideally, individuals would follow the addiction "continuum of care" from

²⁹ The Massachusetts Speaker of the House, Robert DeLeo, spoke to a large audience at the Massachusetts’ Legislature’s annual Recovery Day in the fall of 2012: “As a state representative I get to speak frequently with the people of my district but as Speaker of the House I get to travel around each corner of the state and learn about the concerns of every district, but no matter where I go, the issue that I hear about is the issue of substance abuse treatment and prevention. No matter what part of the state—north, south, east, west, central—poor communities, so-called rich communities, middle class, wherever they may be—this is the issue that I hear the most about. It’s an issue that touches everybody. I’ve heard countless stories about loved ones and the fear of dependency and addiction. And as I always hear about substance abuse prevention and treatment programs could have saved a life. Far too many people fall victim to substance abuse. It’s an issue that we in the legislature cannot ignore...I don’t know if you realize but there was a time when I was getting more calls to get people into treatment than I was about getting kids into college.”

detoxification, also know as Acute Treatment Services or ATS (five to seven days) to a transitional support services (TSS) or a clinical stabilization services (CSS) program, usually 30-days, then on to a longer-term residential program, anywhere from two to twelve months, then to supported sober independent housing. The optimal treatment time is one to two years. Most people do not make it along this continuum, with the majority falling off after detoxification.

Those that do move on past detox usually enter 28-day programs for post-detoxification services. 28 days is a short time to get one's entire life in order, but many people might stop treatment after completing one of these programs. A few people manage to move into long-term residential programs. Because these programs tend to be relatively expensive, they are increasingly few and far between. These slots are almost always inevitably filled, especially the programs that have a reputation for being high quality that might only have space for ten or twenty people. Then individuals are graduated to residential independent living in sober houses or halfway houses. These are often spaces of relapse and sober houses and halfway houses offer a wide range of quality, support and services. Most drug users tend to know which ones are "jokes" and which ones are "strict."³⁰

There is also a tier of treatment that most incarcerated women will never be able to access, the present-day sanitariums: private, residential "luxury" rehabilitation clinics in resort locations like Malibu, Palm Springs, Mexico, Tahiti and the like. They have names like Suncoast, Twelve Oaks, Lakeside, Promises and Destin. They guarantee privacy and luxurious surroundings and tend to not take insurance; they advertise to educated elites, offering individualized psychotherapy, group counseling and luxury activities like massages, hikes, yoga,

³⁰ "Many comprehensive programs do exist, often as holistic "one-stop-shop" treatment programs that provide housing, employment opportunities, substance use treatment and counseling, trauma treatment, and even on-site medical care and family reunification. SSTAR in New Bedford, Massachusetts, is one such organization that attempts to simultaneously address the variety and depth of the needs of women with addiction.

and meditation. The length of treatment depends on how much you are willing to pay, but these programs can cost tens of thousands of dollars and be upwards of a year or more.

Then there are outpatient programs, including day programs with group counseling and outpatient maintenance programs for heroin or opioid addiction. One of my field sites was a public suboxone clinic run by the Department of Public Health. It had a reputation for being one of the “good” ones, long experienced in dealing with addiction. Yet it struggled within a system overburdened with the needs of the most vulnerable patients and was always under financed.³¹ Why weren’t public addiction programs built up instead of prisons? As the neoliberal logic of Partners Healthcare shows, it is easier to shut down under-resourced programs struggling to fulfill their mandates rather than to fully resource and staff services for the poor and disenfranchised sick.

Philosopher Felix Guattari writes: “There is a kind of criminalization, a stigmatization of certain segments of society induced by that kind of absurd perspective—a perspective that consists of assuming it is order, law, discipline, or constraint that will change the state of this malaise” (2003:206). He argues that

the distinction between hard and soft drugs is, in the final analysis, rather artificial... it is always the same nervous system that is afflicted by “what happened,” the forms of administration, the material, subjective, and social assemblage (*agencement*) of drugs. In other words, what counts are not only the physiochemical characteristics of drugs but also the style of buying, the atmosphere, the context and the myths. (Guattari 2003: 201)

³¹ The clinic struggled to give comprehensive care: to join the clinic, they mandated a physical examination or proof that a patient was enrolled in primary care elsewhere, as well as participation in psychotherapy and/or psychiatry. It was almost impossible to get a new visit appointment with the staff psychiatrists, though, since they were so overburdened. It was often hard to get patients to see the addiction counselor and to mandate that was an essential component of treatment.

Not all programs try to be good. People cycle in and out of them, for various reasons non-completing the programs (to go out and use again, because of fights or disagreements with staff or other residents, because of rule violations). Many programs struggle—spending valuable staff time changing people’s health insurance plans to get better addiction treatment coverage—and they have to figure out how to stay afloat, how to bill so that they can pay the staff—even if it means billing for trips to Walgreens as “group therapy.” The programs know that they have only a small slice of time to work wonders, to enact cures, to do magic. It is easy to understand how staff can get run down, why patients so often defect.

Yet what happens when the myths—the discourse of fear and risk based on notions of contamination—generate new realities? These are realities that are produced “when the sense of social order is threatened...boundaries between the individual and political bodies become blurred... individuals may express high anxiety over what goes in and what comes out of the two bodies” (Scheper-Hughes and Lock 1987: 24). High anxiety over drugs has real political capital, resulting in largely intractable, punitive policies that have devastating consequences for the poor and marginalized.

The Quest for Health and Wellness

Guatarri notes that addiction to drugs is only one facet of addictive behaviors that are the cultural tendencies of late capitalist modernity: “It is our entire society that is drugged, that “hardens” its drugs, and that connects them increasingly to a taste for disaster, to a drive for the end of the world” (Alexander and Roberts 2003: 202). He argues that we all, to some degree, fixate and function around various unhealthy obsessions; he points to watching television as particularly pathological but hardly criminalized. As they say in Narcotics Anonymous, members don’t have a “drug problem” but a “thought problem.” The disease of addiction is in our brains, our worst thoughts, our desires.

The object of our fixations and desires can be commonplace to exotic: food, sex, exercise, work, gambling, television, increasingly the Internet. Natasha Schull, in her work on gambling addiction and the manipulation of desires by the casinos and the manufacturers of slot machines, contends that gambling addicts seek to lose themselves in the machine, to escape and dissociate from reality, mired in an increasingly soothing relationship between oneself and the object of one’s desires through repeated encounters. One of her informants plays video poker in

the gas stations or the casinos in order to “forget his profound loneliness, his tense relationship with his adult son, a drug addict, and the situation that awaits him at home, where he acts as a sole caretaker for a bedridden friend” (Schull 2012: 187). Schull uses the work of Hungarian “positive” psychologist Mihaly Csikszentmihalyi to wonder how we can either flow toward self-actualization “transcending the constraints of their reality of creating new realities” or we can ‘escape backward,’ dulling their experience of reality through the repetition of behaviors that seldom lead to empowering affective states or open new possibilities” (Schull 2012: 167).

So the seeds of addiction live in all of us but are actualized by acting on our desires and to what extent we do so. What substances and objects do we all variously utilize as we seek to minimize pain and maximize positive feelings? What historical, geographic and sociocultural tracks lead us toward certain objects and not others? What struck me in conducting this fieldwork was the fine line, the seemingly arbitrary distinctions, in our social responses to suffering and quests for well-being. As I struggled with my own sense of self-worth, belonging and efforts to cultivate healthy relationships and a sense of community, I felt strongly that opiate addiction or its treatment was not that different from other means to achieve a good life.

But drug addicts and treatment providers need to locate the pathological difference between “us” and “them.” Narcotics Anonymous tells its members that they are not normal; one early Addicts Anonymous text from 1949 *Our Way of Life* Magazine reads, “The delusion that we are like other people, or presently may be, has to be smashed” (Budnick, Pickard, and White 2011:N.P).³² Therapeutic communities, mutual aid/self-help drug treatment programs and

³² It reads “Most of do not like to admit that they are emotionally and mentally different from any of their fellows. Therefore, it is not surprising that their careers have been characterized by countless vain attempts to prove that they could administer drugs to themselves without becoming addicted. The idea that somehow, some day, should they do this or that, they will be able to control and enjoy their drug-taking is the great obsession of many addicts... The persistence of this delusion is astonishing. Many pursue it into and through the gates of insanity and death.” (April 25, 1949, *Our Way of Life*)

psychoanalytic or cognitive-behavioral orientations—all utilized to some extent in prison-based settings—emphasize that drug addicts are different from the rest of us. They have an altered, alienated way of being-in-the-world, leading to maladaptive, unhealthy, self-centered and self-injurious thoughts and behaviors, including law-breaking and criminality.³³

Prisons have historically been spaces for social and religious reformers to meditate on the behavior change of those deemed deviant and morally bankrupt, but drug treatment is a relatively recent technology of carceral behavioral change. Michael Meranze (1996) has called prisons “laboratories of virtue” where spiritual interventions were devised for the deviant and disordered soul and physical interventions for the body. The figure of the “criminal” was someone whose characteristics could be known and quantified, his diseased mind and character traits studied and altered. Part of these orientations to studying and reforming criminals came from eugenic groups that sought to identify and eliminate the so-called degenerates, the feeble-minded, the inebriates in the name of the fitness of the entire population. Eugenics is unfortunately still a strong facet of the punishment of women on drugs. Only three years ago, a non-profit organization sponsored by a right-wing billionaire offered voluntary sterilizations to women on drugs for \$300 (Lee 2010). In California in 2013, at least 148 women were sterilized without proper authorization under the authority of the state women’s prisons at outside hospitals (McGreevy and Willon 2013). Interventions on women’s bodies and their reproductive capacities—especially on women with low healthy literacy and multiple structural disadvantages—are a form of violence that must be

³³ In *Drug and Alcohol Education: A Long-Term Workbook* produced by Hazelden Foundation in Minnesota, they define the six major parts of the disease of addiction as: 1) It’s an illness; 2) It’s chronic: “Once you turn into a pickle, you can’t go back to being a cucumber 3) It’s progressive 4) It causes “social” death: “Eventually, you will be removed from your community and incarcerated like you are now. There are many routes to incarceration—vehicular homicide, dealing or buying illegal drugs, violence while under the influence, and more. Regardless of the path you’re on, all drug-using paths for addicts lead to social and physical death; 5) It will kill you: “It’s only a matter of time. You can count on it” and 6) not drinking/using is the only cure (Hazelden 2002: 44-45).

reckoned with (Roberts 1997; Richie 2012). It is violence of the most insidious sort under the auspices of promoting health.

The World Health Organization, in their *Health in Prisons* report, captures the problem of health education and informed decision-making in prison treatment. Unfreedom tends to make one unhealthy: “One of the central pillars of health promotion is the concept of empowerment: the individual has to be able to make healthy choices and has to be allowed to do so. In health promotion in prisons, this approach is not possible. It is therefore important that as much empowerment as possible be built into the prison regime” (World Health Organization 2007:5).

The provision of health in prisons is a contentious arena. By law, prisons must provide healthcare to people incarcerated within their walls and prisoners usually lose outside health insurance upon incarceration. Prisoners, in fact, are the only population specified in the constitution that have a right to adequate healthcare as the Supreme Court ruled in *Estelle v Gamble* (1976); deliberate failure to provide adequate medical treatment was ruled as cruel and unusual punishment, a violation of the 8th Amendment.

It is a difficult demanding task to provide humane, compassionate care to individuals who have high rates of chronic and infectious diseases in addition to the kinds of conditions that plague the general population (Hammett, Harmon, and Rhodes 2002; Rich, Wakeman, and Dickman 2011; Spaulding et al. 2009). People coming into prisons and jails have often neglected or been unable to access steady preventative medical care. While prison-based healthcare is not the specific focus of this dissertation, it is critical for any assessment of women’s sense of overall well-being. Are their symptoms addressed, are their concerns dismissed or validated, are their bodies and minds attended to with proper diligence, speed and compassion?

It is increasingly a fraught proposition to provide adequate medical and psychiatric care in prisons and jails with the turn to for-profit prison healthcare, in which denying inmates' requests for treatment and denying costly medications or treatments translates into cost-savings and profits for the company. During the time that I initiated the project and finally completed the fieldwork, the healthcare at the Boston jail, the Suffolk House of Corrections, had changed hands twice. Originally run by a company called PHS (Prison Health Services) with a big cross rising out of the inside of the H on the company's logo, PHS merged in 2011 with Correctional Medical Services, forming a company called Corizon. Corizon, based out of Tennessee, has contracts in over 400 prisons and jails in 31 states, providing healthcare for over 400,000 inmates.³⁴

Psychiatric illness is particularly prevalent in prisons and jails, partly due to the closure of state mental institutions in the 1970s as part of the community mental health movement (Krieg 2001; Baillargeon et al. 2009). I met very few women who did not bear multiple psychiatric diagnoses. It was extremely common for them to list off a litany of disorders, particularly mood disorders like depression and anxiety but also commonly PTSD and bipolar disorder. Many of them also had been told they were borderline, a common personality disorder attributed to “difficult” women marked by self-injurious behavior, while incarcerated men are frequently told they have “antisocial” personality disorder (Zlotnick 1999; Rotter et al. 2002).

³⁴ Corizon felt like it was difficult to provide adequate healthcare at the Suffolk House of Corrections. One of the staff members told me about entrenched corruption, lackadaisical attitudes towards the provision of care, and staff that were antagonistic to inmates whom they viewed as self-serving, filling out sick slips in order to get attention. They were constantly seeing inmates who complained that they needed a “bottom bunk” for health reasons and wanted a sign-off from healthcare providers that it was necessary. They were constantly refusing requests for medications for sleeping, since many of them slept during the day and the lights and noise of being incarcerated disturbed their nocturnal sleep processes. A year before I began my fieldwork, Corizon was abruptly terminated, partly due to the death of a federal immigration detainee who had complained of chest pain and was told to take Motrin and died of an untreated heart attack (Sacchetti 2011).

Naphcare, a for-profit prison healthcare company based out of Birmingham, Alabama, took over immediately in “an emergency 18 month contract” in March 2012. Sheriff Andrew Cabral argued that NaphCare seemed capable of providing for the large jail, and they probably had under-bid the local systems such as the University of Massachusetts Medical Center: “We are looking forward to fully exploring the benefits of a customized electronic medical records system. It is a tremendous tool for the risk management of all inmate medical and mental health issues” (NaphCare 2012).

Young women—women in their 20s and their 30s—largely did not have chronic medical problems. Many had acquired Hepatitis C but did not feel unwell from it nor were they ever engaged in discussions about treatment. They tended to avoid seeing medical at all costs. The older women more frequently engaged with the jail’s medical staff. Carol, a 44-year old white woman from South Boston had a massively distended swollen belly of unknown cause, her skin stretched taut in a mimic of pregnancy. The jail was investigating if it was due to an allergen, something in her diet (gluten, one of the administrators suggested?). I tried to conceal the doubt written all over my face. She also had shortness of breath, Hepatitis C, possibly cirrhosis, unknown masses in her lungs and spine, an amputated leg and chronic lower back pain from two flip-over car accidents. I thought it had to be ascites, but no one mentioned that word.

Carol hated going in chains to the local hospital with a contract in order to see the oncologist. She hated going because all the patients had to wait in a tiny room in the basement of the hospital and the discomfort of her distended belly caused her pain: “So I can’t lay down because the chain hurts my stomach, sometimes you have to sit there five or six hours until everyone’s done.” But she was actually glad to be able to take care of her health concerns in jail because on the outside “I took care of everybody. I try to do right by everybody but when it comes down to myself... I’m not used to that.” The other inmates look to her as a mother figure in the jail, but she doesn’t want to assume that role inside: “I’ve been asking God to please clear a path so I can take care of myself, because that’s the one thing I’m unfamiliar with. My roommate detoxing from methadone begged me to show her how to make the bed, but I just don’t want to take care of everyone here.”

She tried to establish the reputation as the angry older loner willing to fight the younger women: “Stay the fuck away from me. If I hear that you’re trying to talk shit about checking

your meds or whatever the fucking case may be...” she trails off. She doesn’t want any temptation to use because “this place can really get to you and sometimes you don’t have any escape, because it’s like a madness in your head, you’re stuck here.” It is hard for her to accept the healthcare here, since most of her care has been at one of the local Harvard hospital systems that she believes saved her life after her debilitating car accidents (the opiate addiction she developed as a result of prescription opioids was not the hospital’s fault, but her own).

Feeling adequately treated by medical and psychiatric staff was only one necessary but not sufficient factor in the subjective sense of well-being among incarcerated women. Women who use drugs have over time become keen judges of medical personnel and the stigma associated with being a drug user. They do not stand for it on the outside, although at the prisons and jails, they have no choice. They cannot sign themselves out “against medical advice” or leave the emergency room after being pegged an addict, unworthy of treatment, deserving of only punitive stabs for IV access for shrunken, receded veins. Dr. Gabor Mate, an addiction physician in Vancouver, writes that “they can tell instantly whether I’m genuinely committed to their well-being or just trying to get them out of my way. Chronically unable to offer such caring to themselves, they are all the more sensitive to its presence or absence in those charged with caring for them” (2008:25).

I found that health was a fairly low priority for incarcerated women dealing with addiction. Perhaps it was because they felt excluded and judged as unworthy, lacking in what Sarah Willen has called “health related deservingness” (Willen 2012a; Willen 2012b). But health rarely falls into the top five of their priorities for their lives in prison or their lives after. As a medical student, I found this disheartening. So going to the clinic was unimportant, it was something you’d blow off? Honestly, yes, many of them said. How then could the clinic be a

place where we could address the structural violence in your life, help you get comprehensive medical and psychiatric treatment, try to help you access housing and employment? In short, how could the clinic be the answer?

The Prison As A Site for Drug Treatment

The prison is a unique space for healthcare and treatment of any kind. How can a place of barbed wire, cells and guards be also a space of healing? When I first arrived at MCI-Framingham, the state women's prison, I was struck by the rolling, grassy campus-like appearance, the ancient, crumbling bricks of the buildings. It looked like a small liberal-arts college for women, if it wasn't surrounded by densely coiled layers of barbed wire. Everyone enters Framingham via the Betty Smith building, an imposing, sterile and brightly red brick building that houses the "trap"—the nether zone that is neither fully in the prison nor outside of it—as well as the Close Custody Unit ("the hole") and administrative offices. Getting inside into the prison compound can easily take thirty to forty minutes, depending on the line and the diligence of the officers working that particular shift.

Most of my interviews were conducted in an ancient, crumbling building called the Old Ad ("Old Administration Building") where the majority of the programming occurred. The high ceilings, the darkly wood paneled walls, the dusty glass windows were reminiscent of a Victorian reform school. The women did many things in this building: they had the hair salon and the culinary arts training, recreational spaces and several classrooms. Women walked the halls in their green DOC-regulation sweatshirts, some trailing puppies behind them as part of a dog-training program.

I did not have access to the places of the most un-freedom or the places most reviled: the HSU detox and the CCU or "the hole." The women who had been to "seg" told me how

important the windows were from which they could peer out at the “tree.” The tree was critical to feeling connected to the world. An inmate’s friends or girlfriend would stand by the tree whenever she could, in eyesight and solidarity for the person in seg. The tree in the yard was life, a reminder of common humanity and virtual companionship.

The women’s prison is a truly complex social institution; it is integral to examining cultural sensibilities and orientations to the right and wrong behavior of women, to a society’s notions of human malleability and the possibility of change, to primal feelings of risk, safety and danger. It is a space that is informed by and integral to notions of political economy and governance itself, a space for meting out justice (or lack thereof), punishment, simple detainment, and increasingly, now treatment. As Lorna Rhodes (2004) wonders in her ethnography of a super-maximum prison in Washington State, what does the treatment of those deemed the most bad tell us about our ability to exclude and abandon others largely more vulnerable than we are? And the prison shapes concretely the life chances of the millions of people who pass through its thick steel doors, condemning generations and classes to lives marked by the long shadow of the prison, including enduring stigma and limited economic opportunities.

Contrary to Foucault’s classic work on power and prisons, *Discipline and Punish*, the prison is more than just an institution of social control and a site for the training and knowing deviant bodies. The contemporary American prison is an incredibly complex, multi-faceted institution that combines elements of social, racial, class-based and gendered control; economic and legal facets; punishment of persons seen as deviant, transgressive or otherwise threatening/harmful; fulfillment of the colonializing, civilizing mission inherent to so many

forms of governance. And we must not forget that the prison serves our very primal urges to punish others, to obtain vengeance, to exert moral authority on others, as Durkheim has argued.

According to Durkheim, crimes are actions that violate a society's moral conventions, or a "conscience collective." Crimes also stir individuals to desire vengeance in the form of punishment. As sociologist David Garland writes in an analysis of Durkheim's notions of punishment, "Passion lies at the heart of punishment... [Crime] serves as an occasion for the collective expression of shared moral passions" (1990:32-33). Having a common enemy and punishing that enemy solidifies individuals together, affirming their shared value system and moral authority, contributing to the social cohesion of the group.³⁵

A modern analysis of prisons and jails as they fulfill one of their roles, therefore, cannot leave out the individual and group passions towards people seen as offenders of criminal/moral orders. When it seems as if "mass incarceration" doesn't make "sense," it certainly appeals to society's sense of order and in some cases, demands for vengeance and simple incapacitation—not rehabilitation. As Kai Erikson (1966) has written about the Puritans in the 1600s, the very marking of some individuals as deviant, as witches—and suffering the fatal consequences at the hands of the collective—in the Puritan Bay Colony was necessary to mark the moral boundaries of the group and to knit the rest of the community together.

Georg Rusche and Otto Kirchheimer, students of the Frankfurt School of social research, have argued that the prison is an institution of class oppression that serves the interests of those in the ruling class. In *Punishment and Social Structure* (1939), they posit that the prison is one form of a larger means of controlling the impoverished classes. The prison is knit into the history

³⁵ Garland writes that it affirms the group's moral authority: "We inflict various degrees of suffering and hardship upon the offender, not for what they can achieve in themselves, but in order to signalize the force of the moral message being conveyed. Physical harms, prison cells, monetary penalties, and stigmatization are thus for Durkheim so many concrete signs by which we express disapproval, reproach, and power of the moral order" (1990:44).

of other institutions such as the poorhouse, the insane asylum, the hospital, the school and the factories that serve to quell and control the poor masses. The value of penal labor and making the poor produce cheaply *en masse*, they argue, contributed to the economic profits of the bourgeoisie. Criminalizing the poor for crimes committed out of poverty or for survival—increasingly against the property of the rich—was another aspect of punishing the poor (Wacquant 2009). Their marginality from mainstream social conventions and institutions “carried with it the menace of the unpredictable and the unattached. The destitution of this class was also its danger” (Garland 1985: 40). Garland contends that the incarceration of the poor had practical and symbolic effects: “Most practically, it displaced or dispersed any political threat by isolating and detaining individuals, breaking up neighborhoods and families, deterring resistance by threat of force, and making impoverishment shameful and degrading... The prison and the workhouse ... routinely displaced the problem to the level of individual morality, thereby denying the structural effects of unfreedom and any implied demand for the state to counteract them” (1985: 52).

These theoretical orientations towards incarceration—political-economic, social-psychological and through a lens of power and class—are not inaccurate vantage points to view the contemporary prison, but they do not fully grasp the rise of the prison’s therapeutic ideal and these implications. The prisons have increasingly become places for treatment, for the rehabilitation of criminalized drug addicts incarcerated under “War on Drugs” policies like mandatory minimums. Some people actually get sent to prison because the judge believes that the treatment programs offered there are better than existing community alternatives. This is not uncommon. The prison is now a dominant space for turning the mad and the bad into well-adjusted, productive and properly moralized citizens.

Christopher Nolan, a sociologist who studies drug courts, has argued that with the rise of the ‘psy’ discourses (Rose 1990) and a therapeutically-oriented culture, we have moved into an era of the therapeutic state that is increasingly dominated by psychological and social work discourses and Christian notions of sin and redemption. He examines how seemingly liberal and humanitarian practices are employed by drug court staff in orchestrating “therapeutic justice.” This shift leads to intrusive forms of surveillance in which individuals brought before the court are held responsible for their pathological traits and behaviors; the courts see themselves as curing them of these bad traits, such as low self-esteem, by being their cheerleaders and social supports.³⁶

Nolan is quick to point out that “the treatment perspective, like previous understandings of criminal behavior, is not neutral” (2001:133). The treatment paradigm currently dominates penal rhetoric, but why is it so dominant and how does such a paradigm affect women who undergo prison treatment? Does it alter their sense of selves, their chances at well-being, their tendencies towards criminal thinking? Or does it reinforce conventionally held notions of failure and point to internalized pathology as the source of unrepentant lack of wellness, if drug use (and criminal behavior) is depicted as a rational choice by one’s persistence in making poor decisions?

Changing attitudes towards addiction are increasingly altering not only criminal justice practices but even everyday lives of local citizens. William Garriott’s ethnography of methamphetamine and policing in West Virginia presents evidence that addiction is seen as a good reason in and of itself—besides the fact of innocent or guilt—for incarceration. As Garriott finds, “On the contrary, Dwight’s “severe drug addiction” was cited specifically as a reason to expedite his incarceration and deny consideration of any therapeutic alternatives (other than

³⁶ Nolan argues that the relatively new drug court programs had to justify their existence within what Jurgen Habermas had called a legitimization crisis: “There is an ongoing need for state programs (including those within the criminal justice system) to justify themselves according to the dominant values” (2001: 57).

those he might receive while incarcerated)” (2011: 73). In fact, medical issues related to meth use are neglected since suspected drug users and criminals always claim that they need treatment: one of Garriott’s informants in the Federal Drug Task Force tells him, “I see treatment as an easy getaway... Some people call me hardcore, but I think jail’s the best treatment for them” (2011:20). Garriott observes how the moral panic around methamphetamine allows the police and surveillance systems to reach into homes in new ways, a form of “domestic militarization” he calls narcopolitics, that is, “any practice of governance whose rationalization lies in the concern with narcotics” (2011:5).

Bad Habits: Women’s Drug Use as a Moral, Criminal and Existential Problem

“Never let it be forgotten either by the framers or dispensers of criminal law, that the stimulus of shame, like other powerful medicines, if administered in too large a dose, becomes a deadly narcotic to the moral patient!” -Samuel Taylor Coleridge (Davenport-Hines 2002: 72)

“Excellence, then, is not an act, but a habit.” -Aristotle

Current United States legislation on drug use defines "addict" as “any individual who habitually uses any narcotic drug so as to endanger the public morals, health, safety, or welfare, or who is so far addicted to the use or narcotic drugs as to have lost the power of self-control with reference to his addiction” (United States Congress 1966: 1438). While using the term addicted to define addict does not lend additional clarity, this is a sweeping definition that liberally interprets notion of risk and harm and links them to notion of self-control. The earliest usage of the term “addict,” the past participial stem of *addicere*, was used in Roman law as “to bind to the service of” or “to deliver or hand over formally (a person or thing) in accordance with a judicial decision (Oxford English Dictionary Online 2010). If a person failed to pay one’s debts, he could be bound legally by a magistrate to one’s creditor. One was bound, attached, and

even devoted. A more rare definition stated that an addict could be someone who “practiced devotion to an occupation, activity or object.”

The ancient Roman usage of the term implied that one was turned over to one’s creditor for an unpaid loan, but one was bound to another only as a result of a decision to take a loan in the first place. So the question of volition, and of the implication’s of one’s decision-making—even, albeit, in conditions of structural violence and poverty—was and is central to even the historical notion of the addict. It is this question of choice that puts it squarely in the realm of moral, that is, the realm of virtue and vice, of how to live in a right way. Choosing the right path—and the proper consideration of one’s decision—was critical to one’s ethical behavior. Historian Darrin McMahon, in his study of nations of happiness and virtue, writes that “the implicit assumption is that those living in bondage or sin are not worthy of happiness” (2004:6). The modern-day addict, living in both bondage (to substances) and sin, has failed to choose the right path. We culturally affirm the choices we make and the implications of those choices for our lives; as McMahon writes, “Taking his cue from Socrates and Plato before him, Aristotle avowed faith in human agency, in our ability to control our fortune by controlling our actions and responses to the happenings of the world” (2004: 8).

The crux of addiction, though, was that one consumed to excess, to loss of control. While consuming and imbibing some substances like alcohol, a legal drug, was tolerated, one had to moderate for the sake of one’s own health and the potential harms that existed to others. Of course, where this limit is differs for everyone; as feminist criminologist Marianne Valverde notes with alcohol, “But the search for objective measures [of risk of harm] is in this area stymied by the fact that what is or is not a harm, in the context of drinking, is itself subjective.

What appears to some as a normal Saturday night might be regarded by others as dysfunctional, harmful, and therefore pathological behavior” (1998: 26).

Excess consumption of certain substances—for the wrong reasons: for hedonism, physical pleasure, for seeking oblivion—was a way of marking deviant behavior. Leo Tolstoy wondered why people used these substances as he mused on his younger days of drinking and gambling. Tolstoy, in an essay written in 1891, explored the most common reasons offered for drinking and smoking by his contemporaries—for example, to “drive away melancholy” or “because everyone does the same” (2003:41)—and ultimately rejected them in favor of what he saw as a deliberate attempt to stupefy and muffle the voice of conscience that spoke from within each individual about how to move towards moral enlightenment. Tolstoy felt that even moderate drinking, smoking and drug use signified the tension between the fact that “man is at once a spiritual and animal being” (2003: 55). He was concerned that partaking in drinking and smoking was not only an evil at the level of the individual but also that it significantly hindered the progress of the entire human race. Tolstoy did not want to seriously entertain what he called the “animal” motivations behind drinking and drug use; for him, the spiritual and moral realm was unquestionably a superior position in every way. It was a choice to live in the spiritual and morally upright realm.

Yet most would agree that the choice to use substances can easily morph into a habit, an everyday indulgence into a habit then a necessity. Valverde, in her work looking at alcoholism as a disease of the will, examines why habit became seen as a space for intervening on morality. She examined how the World Health Organization struggled to define what a habit-forming substance was, ultimately coming up with three categories: psychological habit-forming (less dangerous), alcohol, an intermediary category, and dangerous, “habit-forming” drugs like heroin

and cocaine (1998: 40). Yet was habit necessarily a bad thing? According to the pragmatists William James, Charles Pierce and John Dewey, habit is what keeps society functioning. When individuals engaged in their daily habits, it maintained the status quo in social divisions: “It alone is what keeps us all within the bounds of ordinance,” William James wrote, “and saves the children of fortune from the envious uprisings of the poor” (1914:51).

One could not change one’s habits by sheer desire to do so, but rather by endless grit, willpower and changing one’s neural circuitry with repetition. In terms of alcohol treatment, successful treatment necessitated “a valiant effort of the diseased will to overcome its disease... freedom cannot be instilled into people by force or through medication: the will’s capacity for freedom can only be built upon by freely exercising that very will, however diseased or out of shape it might be” (Valverde 1998: 33). James felt as if habits were a form of literally embodied hard-wiring. Every action, good or bad, was physiologically imprinted: “We are spinning our own fates, good or evil, and never to be undone. Every smallest stroke of virtue or of vice leaves its never so little scar” (James 1914: 67). The goal of changing one’s habits included acting upon one’s environment as well as one’s internal forces; as James wrote, “Accumulate all the possible circumstances which shall reinforce the right motives; put yourself assiduously in conditions that encourage the new way; make engagements incompatible with the old; take a public pledge, if the case allows; in short, envelop your resolution with every aid you know” (James 1914: 55).

And even more so than with addiction, being a criminal was seen as a choice and a total moral failure. One could be brought up in poverty, see one’s parents engaging in criminal thinking and behavior, even be socialized to become a criminal as a child, but breaking the law was and is still largely seen as an immoral choice. One could even become a career or a “habitual” criminal, but habit was no excuse for crime. As David Garland has written, “The twin

doctrines of individual responsibility and presumed rationality formed the basis for the judicial findings of guilt—since in free-market society the criminal actor, like his economic counterpart, was deemed to be in absolute control of his destiny... Illegality, like poverty, was an effect of individual choice” (1985: 17).

Here I want to examine the so-called “bad habits” of women on heroin who are called and labeled criminals in our society. Habit is a way of thinking through not only ritualized patterns of drug use, but also deeply embodied ways of being in the world. Most importantly, habits are seen as sites for intervention, and they are always “politically and morally freighted domains, relations of power—or for that matter, relations of virtue” (Ong and Collier 2005:17).

Habits consists of much more than instinctual drug use, although people describe the fact of becoming physically dependent on a substance with subsequent withdrawal symptoms in the absence of opioids as having acquired or “caught a habit.” Narcotics Anonymous would say that addicts have a variety of bad habits: selfish actions, lying, cheating, swindling others, self-deception, patterns of thought. They have habits of both action and non-action, doing and not-doing. It is an engrained habit to play up the sick role, to charm and manipulate others. It is a bad habit to no-show on doctors. The Women’s Recovery Academy, a “modified therapeutic community” at MCI-Framingham, tells women that their deviant bad selves (the ones that landed them in prison) is the “habit self.” This exists in contrast with the “inner self.” The habit self, according to them, is “the voice in your head that automatically says things about what you like or dislike or what you want to do. The habit self doesn’t think. It just reacts on feeling and memory.” The inner self, on the other hand, is “the part of you that is responsible, thoughtful, and reasonable... the inner self doesn’t get triggered into aggression or defensiveness like the habit self.”

<u>Habit Self</u>	<u>Inner Self</u>
I choose not to listen	I choose to listen
I choose to reject	I choose to accept
I choose to forget	I choose to remember
I choose to behave the old way	I choose to practice a new way
I choose to remain stuck in my old ways & old behaviors	I choose to change
I choose to give up on me	I choose to believe I'm worth it

Table 2.1: Habit self versus the inner self, from WRA Participant Handbook, last revised 2010

Examining efforts to break the “wicked bad habits” of women on heroin—for their own sakes as well as ours, many would say—is a way to examine both means of governance as well as spaces of ethical intervention. It is a commonly held American belief—consistent with Calvinist notions of work—that good habits lead to good lives: people who are materially successful, work hard and choose paths of moderation often attribute their success and well-being to habits. On the other hand, bad habits—idleness, vice, seeking excessive and indulging oneself in corporal pleasure—lead to lives of sin, immorality, and poverty (O’Malley and Valverde 2004) . Habits themselves become markers of character and increasingly class. To be addicted violates many kinds of strongly cherished notions of American autonomy and strength, signifying dangerous dependence, weakness and immorality.

Part of the justification for intervening on bad habits is the general sense that they are contagious, they are larger than themselves, that contact with a drug addict will lead to a proliferation of drug addiction (Wald 2008). Bad habits, in this sense, are stronger than good habits. Women who were sent to the early Houses of Correction in Detroit were detained indeterminately for up to two years time under the condition that “reformatory advocates argued that they needed time to ‘break up, if possible, old habits and associations, and bring the inmates

under that moral and religious influence, without which little hope of permanent reformation can be expected” (Rafter 1990:38).

Foucault notes that intervening on habits was integral to reformation of the criminal subject: “Ultimately, what one is trying to restore in this technique of correction is not so much the juridical subject, who is caught up in the fundamental interests of the social pact, but the obedient subject, the individual subjected to habits, rules, orders, an authority that is exercised continually around him and upon him, and which he must allow to function automatically in him” (1995:129). In Foucault’s discussion of the making of docile bodies, he shows how schools and the military command exact principles, gestures and movements on specific time-tables in order to make self-disciplining and self-surveilling subjects. But as we know, old habits die hard. They can rarely be beaten out of people.

Are bad habits actually contagious? This is a question for epidemiologists and social network researchers. Maybe it doesn’t even matter: the perceived contagion exists. There is a definite fear of the drug user as contagious, as infecting an innocent, healthy other into becoming a risk-taking, diseased pariah. This played out at its peak in the 1980s AIDS epidemic (Treichler 1999). Fear and perception become reality. Drugs, especially heroin, are linked to fears of crime. In a public forum on the implementation of medical marijuana in the state of Massachusetts, a group of concerned mothers from the South Shore spoke of the danger of marijuana. One woman was against it because “with heroin there is a rise in drug-related crimes, fatal and non-fatal overdoses...and there is definitely a risk of home break-ins and that type of problems.” If there are epidemics, it must be catching. Marijuana use leads to heroin use which then leads to crime, right?

Therefore intervening on drug habits is seen to be the key to intervening on criminal habits, although as I hope to show here, they are not one and the same. Habits are another way to know and mark others; they are signifiers of class, education, of learned behavior. Bourdieu's notion of habitus encompasses habits as markers of social status: as he writes, "And finally it is an immediate adherence, at the deepest level of habitus, to the tastes and distastes, sympathies and aversions, fantasies and phobias which, more than declared opinions, forge the unconscious unity of a class" (Bourdieu 1984:77). Much as James had asserted, habits and habitus are ways of maintaining the social distance between classes.

Drug use, especially among youth, has been a consistently vilified and targeted proxy, a scapegoat, for the problems of black Americans and families; for the problems of urban zones of concentrated disadvantage; for the failure of rural impoverished communities; a failure of race relations. It is too easy (and too unwieldy) a target. Howard Stein, a family physician, posits that "in our society, presidents, policy makers and physicians occupy and reign within our cultural Valhalla. Our despised alcoholics and addicts are our trolls; they embody and are made to bear the disavowed wishes and fantasies of 'normal' society...[they] personify the violation of everything we Americans supposedly hold dear, e.g. self-control, the work ethic, the renunciation of current pleasures for future rewards"³⁷ The mainstream needs the margins, in other words, to affirm its own existence and comfortable way of life. We are not forced to examine structural violence and our own complicity on cultural, historical and

³⁷ He also argues that presidents and policymakers have made policy decisions largely informed by psychodynamic problems: "Two psychobiographies of President Ronald Reagan, one by Dallek [51] and another by deMause [52], show how his revulsion against, yet identification, with a brutal alcoholic-father influences policy and value choices in public office. Reagan's constant battle with dependency and his war against drugs, couched in the traditional American 'individualistic spirit,' enact a life-long war against the father whom he cannot forgive and from whom he cannot separate (Stein 1990: 993).

economic paradigms that have engendered and exacerbated the suffering of others. As Lewis Lapham wrote in *Harpers* in 1989:

Because the human craving for intoxicants cannot be suppressed—not by priests or jailers or acts of Congress—the politicians can bravely confront an allegorical enemy rather than an enemy that takes the corporeal form of the tobacco industry, say... the war on drug provides them with something to say that offends nobody ... and allows them to postpone, perhaps indefinitely, the more urgent and specific questions about the state of the nation's schools, housing, employment opportunities for young black men—i.e. The conditions to which drug addiction speak as a tragic symptom, not a cure. (Lapham 1989:45)

Instead we allow ourselves to be obsessed with crime, drugs and prisons as moral panics ebb and flow as a form of social transference and deflection. As Jean and John Comaroff have written about 'criminal obsessions' in South Africa, "Violent crime, here as in the U.S., has become the lightning rod for an escalating range of everyday anxieties—anxieties fed by the insecurity of the privileged as they witness the anger and impatience of those excluded from the promised land" (2004:804). President George Bush exploited our fears of the radicalized other with the Willie Horton campaign against Michael Dukakis, where he used images of a black convict on a weekend furlough committing assault and rape as in order to symbolize the power of Republican (white) goodness over (black, and Democratically-abetted) wickedness (Anderson 1995; Newburn and Jones 2005).

But crime is a sociocultural category and what we choose to perceive as more harmful is a matter of some contingency, as Laura Nader points out: "Little is said about crime in the corporate arena—the powerful destabilizing forces of rampant corporate crime—or the fact that the same forces behind prison privatization are now driving criminal justice policy" (2003:57). It is a question of assessing relative harm: is it worse for one individual to murder another—part of what she calls our "near hysteria on street crime"—or for a pesticide corporation in Woburn,

Massachusetts, to contaminate drinking water resulting in the deaths of eight children (2003: 66)?

I hope to destabilize the notion that drug use and crime are necessarily linked, as well as the corollary that treating drug use or addiction in the prison system will solve our criminal obsessions or tendencies. James Q. Wilson, founder of the infamous “broken windows” (Kelling and Wilson 1982) theory of crime, has written that while there are associations that heroin addicts turn to crime to generate income for drugs, it is largely a product of the black market in which prices are kept high by illegality itself and the constant but unsteady enforcement of drug laws (Wilson 1990: 522). Crime rates are high, in part, by the illegality of heroin and “supply reduction” efforts by the Drug Enforcement Administration (Nadelmann 1989; Reuter 2013).

Many women I met made fine-grained moral distinctions in their addiction-related criminal behaviors; some would not rob strangers only drug dealers (ripping them off by not paying them or stealing pills or heroin) or only would rob “tricks” or “johns.” Most of them strove to do right by their family and their communities more generally; many would rather turn to stealing from their families before stealing from strangers, a different kind of, perhaps equally complicated, “crime” against other persons. The “crimes” that women chose to commit often caused themselves more harm, injury and suffering than what they did to others.

Wilson argued that we needed to be vigilant about how “the heavy consumption of certain drugs is destructive of human character... the pleasure or oblivion they produce leads many users to devote their lives to seeking pleasure or oblivion and to do so almost regardless of the cost in ordinary human virtues, such as temperance, fidelity, duty and sympathy. The dignity, autonomy, and productivity of many users... is destroyed” (1990: 523). My work with women struggling with heroin addiction in the prison system and in the community demonstrates the

endurance of the human spirit and human character in the face of often crushing structural violence, stigma and ongoing shame, in sharp contrast to what Wilson claims is the destruction of human character. They maintained and formed relations of fidelity and love, always seeking dignity and a sense of inherent goodness in marginal alleys and tiny prison cells alike.

I hope to tell stories the stories of women on heroin that can contribute to displacing the prison as a technico-therapeutic solution to our cultural and moral anxieties about drug use. Dawn Moore, a Canadian criminologist, also hopes to trouble the central place that the prison holds for drug users: “The drug user turned criminal addict is a fulcrum of criminal justice, sitting at the centre of both the cause and cure for crime” (2007:1). The prison is a space of ongoing violence for the many women on drugs and it has made itself into a permanent fact of life for the poor. If the prison is a cure for crime or for the problem of drug addiction, it is a not a long-lasting, sustainable, effective, cheap or humane one. Rather, the prison in its forays into treatment has made itself central to drug treatment landscapes—substantiating what Derrida calls the “claim of authority” to exert a “violence [belonging] to the symbolic order of law, politics and morals” (2001: 265).

I hope to shake these claims to authority that the prison makes by investigating women’s narratives of drug use, addiction and crime. Their stories reveal rich emotional lives, quests for well-being and the dilemmas of how to live well and engage in moral actions in the face of suffering, trauma and social institutions that contribute to their sense of risked lives and ongoing anxieties. Women search through drugs and through many other kinds of means for “a sense of a way out” (Jackson 2011:184). As Anna Alexander and Mark Roberts have written about addiction, it need not necessarily be a pejorative notion in which “the addict, as the subject of his

or her addictions, tends to become largely vilified and eclipsed” (2003:3).³⁸ Rather, they might be seen as engaged in existential quests for wellness, creatively using their available means.

American Selfhood, Self-Governance and Failures of Free Will

Drug use, and addiction in particular, has a particularly unique constellation of American roots and responses. Historians have pointed to the emergence of the American junkie as an icon that has been consciously and unconsciously shaped by particular sociocultural formations and movements. David Musto called his book about the history of narcotic control *The American Disease* to reflect the cultural, political and social orientations towards the social problem of drug use that was somehow distinctly American. Caroline Acker noted that the perceptions of junkies as “deviant and unreclaimable” (2002: 1) justified a particularly harsh response; while there was a variety of Progressive reforms—on dancing, drinking, gambling, prostitution, to name a few—in response to urbanization and industrialization and perceptions of moral decay, only some (like heroin use) were legislated permanently into criminality. She notes that the prohibition of alcohol was repealed, and tobacco smoking “had never aroused enough reformist ire to culminate in widespread prohibition” (2002: 3). Heroin addicts, on the other hand, had become “an icon of hopelessness...a potent negative symbol” (2002: 7).

Addiction, simply put, has come to represent a problematic, pathological dependence, a notion that Americans abhor. To be dependent on the government or on others to make one’s way in the world is simply an anathema. As Nancy Fraser and Linda Gordon wrote in their now classic article on welfare and dependency, there were many registers of the word, including gendered and racialized aspects. As they write, dependency came to have a

³⁸ They wonder wistfully what would “modern culture [be] without its perennial outsiders, its incorrigible addicts, its defaced subjects: the smokers, the tokens, overeaters, the alcoholics, the insane and the ‘eccentric,’ and so on?” (Alexander and Roberts 2003: 3).

“moral/psychological” register (1994:315) and the ability to stoically make one’s own way in the world was particularly appealing to Americans in the context of pioneers, frontiers and ideals of the American Revolution that “so valorized independence” (1994: 320). The icon of the poor, black mother on welfare was a particularly strong social symbol because it “conden[sed] multiple, often contradictory meanings of dependency... a powerful ideological trope that simultaneously organizes diffuse cultural anxieties and dissimulates their social bases” (Fraser and Gordon 1994: 327). It was the opposite of freedom, strength and independent living.

In a similar way heroin addiction, and addiction more generally, has come to inhibit a cultural space for fixating and thus diffusing cultural anxieties and fears about contamination, disease and immoral thoughts and behaviors. Addiction represents a failure of self-will and the moderation that Aristotle and Plato had lauded as a means to harmony and *eudaimonia* (well-being). It is a loss of self-control that not only threatens the individuals directly involved in drug use, but the general public at large, making it a behavior demanding punishment, containment and criminalization. In addition, drug addicts’ pursuit of pleasure at all costs and their seeming refusal to work in the formal labor market generates middle- and upper-middle class resentment at the refutation of the values that propel the course of their own lives. Social scientists and historians have noted that resentment is a powerful force in the punishment of the poor, the mentally ill, the disabled, the addicted—or any group that comes to embody the failure of the voluntaristic, boot-strapping American ideal (Bobo and Thompson 2006; Loury 2007; Wacquant 2010; Maskovsky 2005).

Drug addiction was not always viewed this way: morphine addicts historically were upheld for their ability to continue their professions and fulfill their civic duties; for female addicts, many were praised for their abilities to keep orderly households and raise children or

grandchildren. But the distinction between medical addicts and non-medical addicts (viewed as either out of necessity or out of choice) was a critical one for the American context. Francis Anstie observed in his 1864 treatise that there were two types of addicts: “‘the unwary man’ who used opiates to treat pain or illness ... not characterized by a ‘desire to be drunk’ or for oblivion” and the “genuine debauchee” who “love to be intoxicated and craved escape ‘from all the actual surroundings of life’” (Davenport-Hines 2002: 117). The latter, the pleasure-seeker, deserved to be punished; why could she not live with restraint and self-denial that everyone else abided by? Harry Kane, a New York-based physician, observed that there was something quintessentially American about opiate addiction; he wrote that Americans were “essentially a nervous people, prone to go to excess in every thing, gladly welcoming narcotics and stimulants, we go to very decided excess in matters of this kind” (Davenport-Hines 2002: 127). In contrast to Europeans, Americans’ sense of “moral ruggedness, with its clear-cut certainty about the difference between right and wrong” (ibid.) would lead to a moralizing national response that included temperance, prohibitionist, and criminalization.

Among a variety of stigmatized conditions of living, addiction is the ultimate failure and is seen as a willful bad choice. Even more so than mental illness or disability, addiction is seen as belonging almost exclusively to the realm of free will, of choice, at least initially. It is entirely one’s fault, not one’s genes, one’s poverty, one’s family situation. Individuals are supposed to “just say no,” as Nancy Regan’s anti-drug campaign exhorted American youth in the 1980s. Rather than engaging in moderation and the denial of pleasure that so many middle-class Americans espouse as their value systems, drug addicts—no matter what their individual circumstances—at least initially made the choice to consume until excess. It is this excess that is

threatening, linked in the public imaginary to crime and harm to others. It shows lack of restraint and moderation.

Addiction, therefore, is seen as a rational choice to willfully engage in immoral behavior in spite of presumed negative consequences. And the phenomenon of hardcore drug addiction in our midst is a refutation of the American fantasy that we all can make it if we just try hard enough. Contrary to how scientists and policy makers intended a paradigm shift from addiction as a sinful bad behavior to a “relapsing remitting” disease, drug addiction still cannot shake the moral connotations. Ongoing addiction and relapse bear the double burden of immorality as well as a failure to get well, a failure to manage oneself. But unlike alcoholism or smoking (both legal and far more widespread than heroin addiction), the primary social response to any heroin use is incarceration because the substance itself is criminalized, even though the self-harms and harm to others is so vast given the sheer prevalence of the use of these substances. The moderate use of heroin was seen as impossible; heroin was synonymous with loss of control.

Harry Levine, in his classic article “The Discovery of Addiction” (1978), traces a historical trajectory in which habitual drunkenness became seen as a disease characterized by loss of free will and self control. Sympathetic, tolerant attitudes began to shift and in concordance with Enlightenment notions that social problems could and must be solved: deviant individuals, including the mentally ill, were subjected to “moral treatment... now expected to control themselves” (Levine 1978:163). Levine argues that the United States was a country in which ideas about choice, control and self-restraint in the pursuit of one’s livelihood and overall well-being were particularly entrenched. As he writes, “The idea of addiction ‘made sense’ not only to drunkards, who came to understand themselves as individuals with overwhelming desires they could not control, but also to great numbers of middle-class people who were struggling to

keep their desires in check... given the structural requirements of daily life for self-reliant, self-making entrepreneurs and their families” (Levine 1978:165). The United States was a nation dominated by its middle-class and their value systems as theorist Max Weber so keenly observed.

The problem of American selfhood and self-determination runs deep in addiction treatment programs in both the community and the prison. The vast majority of women I encountered viewed their heroin use as a bad choice, a compulsion that they should otherwise resist or shake off. They felt they were responsible for the authorship of lives marked largely by trauma and suffering; their deep convictions about autonomy and voluntarism were a double-edged sword. If heroin addiction was not their fault, then it would ironically take away their very humanity and sense of hope, their sense that they could author or chart a new direction in their lives. But they were also trapped, burdened by structural violence that eroded the options available to them. The prison was a large part of foreclosing opportunities in their lives, constraining the decisions women could make. But to take away one’s responsibility and one’s conscious thoughts and actions would be to deny their agency, their humanity. As Peter Ferentzy writes, the popular and widespread “twelve-step recovery” program is a “strange merger of spirituality and disease conceptions...a moral therapy” (2001: 385). As much as clinical medicine pushes to “own” addiction as a somatic, neurobiological and genetic disorder, people who have experienced pathological drug use or addiction insist it is still a moral and spiritual choice. Alcoholics Anonymous insists in Step 4 of the program that addicts must conduct a “fearless moral inventory” since addiction is a moral disorder. A critical and valued part of Step 4 is assessing the rightness or wrongness of one’s actions and their effects on oneself and on others.

Gene Heyman, a research psychologist at Harvard, asserts that addiction is a “disorder of choice” (2009). He proposes that contrary to economics’ “rational actor” model that individuals do not always act in ways that maximize their benefits. Rather, he suggests that we all know to some extent that our own behavior can both be voluntary and self-destructive. This belief that we can chart our own self-destructive and harmful life courses is one of the foundations of intervening on others in the name of their own safety as well as the safety of others. But it takes a certain kind of dysfunctional personhood—motivated by the politics of fear and danger—that necessitates criminalization. Smoking cigarettes, for example, was never criminalized, but the behavior could easily be conceptualized as a form of both short- and long-term self-harm as well as harm to others (second-hand smoke). Arguably, the medical consequences and harms caused by smoking affect a much larger percentage of the populace. Smoking is a socially condoned, widely prevalent and much slower process of self-destruction than heroin use. We have not legislated punishment and incarceration of people who use nicotine; we do not put them in prison for their failures at rational self-governance as we do with people on heroin. As I hope to show, the prison and its forms of treatment do not turn dependent, pathologized women on drugs into newly reformed citizens marked by financial and social independence or wellness and health.

Chapter 3:

Historical Treatment of Deviance and Addiction at the State Women's Prison: The Problem of Women's Drug Use

"People on drugs are sick people. So now we end up with the government chasing sick people like they were criminals, telling doctors they can't help them... Imagine if the government chased sick people with diabetes, put a tax on insulin and drove it into the black market, told doctor's they couldn't treat them, and then caught them... and then sent them to jail" -Billie Holliday, *Lady Sings the Blues* (1956)

Introduction

Why do women who use opiates outside the purview of a physician's orders go to prison and how have prisons responded to the problem of women who use drugs? To explore the answers to these seemingly simple questions, I turn to historical orientations and attitudes towards women who use drugs and investigate the rise of incarceration as a solution to the problems posed by social deviance. While the War on Drugs came to increasingly bear the face of poor women of color in the 1970s, the incarceration of women for deviance from middle-class norms and lifestyles took place far earlier under zealous Progressive-era reform efforts dominated by religious impulses to save the fallen. What did these earlier attempts at rehabilitation and treatment of the poor, the traumatized, and the socially downtrodden look like?

Notions of gender difference—that women who used drugs are somehow different than men—are critical in understanding the mass incarceration of poor women on drugs. Without societal notions of women as having weaker constitutions and as being more morally pure than men (and therefore more corruptible), many policies and interventions around women's drug use might never have been enacted. The problem of defining gender difference runs into a slippery slope best articulated by feminist and ethicist Carol Gilligan. As she has written, "One problem in talking about difference and the consequent theorizing of 'difference' lies in the readiness with which difference becomes deviance and becomes sin in a society preoccupied with normality, in

the thrall of statistics, and historically puritanical” (1993: xvii). This chapter seeks to understand when and under what circumstances notions of female difference began to inform the epistemological inquiries into the nature of addiction as well as its various treatment modalities, particularly those in the prison.³⁹ How are such gendered notions still taken up and pursued by contemporary actors?

Historically, women on drugs have presented an enigma since they tend to be only a small fraction of total drug users, although what their drug use represented tended to unsettle and disturb the general public much more than the drug use of their male counterparts. The problems posed by female addiction in what Gilligan has called a “historically puritanical” society were myriad: women’s drug use invoked xenophobic- and class-based fears, stirred up latent obsessions with women’s societal and physiological roles as potential or actual child-bearers and was seen as a major barrier for women in fulfilling their traditional gender roles in the domestic sphere. Treatment of female drug addicts tended to work within these pre-established frameworks that reinforced prevailing societal attitudes towards women. Gender ideologies influenced treatment modalities for women that would evolve over time, increasingly stratified by financial means and the ability to pay for discretion.

For decades, the United States Public Health Service’s Lexington Narcotic Facility was one of the better-known treatment options for women. The “Narco Farm” is an important historical institution that symbolizes the convergence of the prison with the addiction treatment center. It was a hybrid institution for voluntary patients as well as convicted federal criminals to

³⁹ Here I work with the concept of drug addiction as limited to mainly opiates (morphine, opium and heroin) and to a lesser extent cocaine. Yet a thorough discussion of female drug addiction cannot escape the long shadow cast by alcohol. Female inebriety was recognized by temperance movements as early as the 1840s, and the Martha Washington Home was founded in Chicago in 1869 for women. While the approaches to the problem posed by excessive alcohol use among women have been analyzed elsewhere (Tracy and Acker 2004; Tracy 2005), I recognize that a discussion of drug use cannot proceed without acknowledging the how notions of female inebriety informed mainstream morality and gendered notions of deviance, personal responsibility and freedom.

detox and undergo treatment for opiate addiction. Yet the majority of women who had run-ins with the law most likely encountered their local state prison facilities and county jails.

Using MCI-Framingham based in Framingham, Massachusetts, as a detailed case study, I explore in what ways and by what criteria this state prison attempted to treat and/or intervene on the bodies and minds of addicted women. How did the prison respond to the problem that addiction posed? The annual reports from the Commissioners of Corrections in Massachusetts (housed at the Massachusetts States Archive at UMass Boston), collating summaries from the prison superintendents over the years, reveal important cultural narratives about crime and punishment, personal responsibility, citizenship and femininity.

MCI-Framingham largely fumbled its way into providing drug treatment over the decades. The “treatment” of drugs and alcohol was always somewhat subsumed into a broader form of treatment: the holistic rehabilitation of criminal women. For the better part of the twentieth century, the numbers of women with drug or alcohol problems in the prison was surprisingly low. It was never an intentional plan that the prison would become one of the largest providers of drug treatment in the state, but legislators filled the prisons with poor women who used drugs. The vast rise in the population of incarcerated women in the 1970s and beyond reflected gendered social attitudes towards deviance largely rooted in emotions like fear and the perception of danger. Ironically, it also might have reflected women’s relatively new equality before the law. Reactionary politics, the rhetoric of “crime and punishment” and public safety, as well as the shirking of medicine to successfully claim addiction as within its purview, all contributed to the overcrowded state of the women’s prison. Critically, notions of female difference and epistemological orientations towards the drug use of women would lead to

different treatment orientations, policies and lengthier prison sentences—the “feminization” of the contemporary War on Drugs.

Treatment of the “Delicate Female”⁴⁰

Historically, women who used narcotic drugs were seen as decidedly different from their male counterparts. Women were thought to be particularly vulnerable to opiate use (laudanum and morphine) and subsequent iatrogenic addiction because of their painful reproductive physiology and the “maximum susceptibility” of their sex. As William Osler, the esteemed American physician, wrote in 1894, “The condition is one which has become so common, and is so much on the increase, that physicians should exercise the utmost caution in prescribing morphia, particularly to female patients” (Pellens and Terry 1970: 545). Women made up a significant percentage of habitual users in the early twentieth century, with estimates between 58.9% and 71.9% (Pellens and Terry 1970: 469).

Some physicians called for special precautions for women seeking treatment as they experimented with detoxification regimens. As James Tyson wrote in 1900, “In the case of women, whenever possible, a special nurse should be assigned to each case” given their tendency to lie and exaggerate (Pellens and Terry 1970: 545). Alexander Lambert and Frederick Tileny, writing in 1926 on their treatment of narcotic addiction with a patented solution known as Narcosan, reported the results of a study conducted among 219 men and 147 women.⁴¹ While the detoxification process was difficult for both men and women, they felt that women tended to be

⁴⁰ H.H. Kane in his 1880 article entitled “The Hypodermic Injection of Morphia,” quotes Bartholow about who is most at risk: “A delicate female, having light blue eyes and flaxen hair, possess, according to my observations the maximum susceptibility.” (Terry and Pellens 1970: 470).

⁴¹ Narcosan, according to the inventors, was “a solution of lipoids, together with non-specific proteins, and water soluble vitamins” that was utilized in concordance with the theory that narcotics call forth protective substances that neutralize them; narcosan neutralizes toxic substances released by the body during withdrawal. In Alexander Lambert and Frederick Tileny—1926 “The Treatment of Narcotic Addiction by Narcosan.” Medical Journal and Record. December 15, 1926. Vol. CXXIV. No 12 (Terry and Pellens 1970: 764-768).

more difficult, as “the women...are more likely to become wildly hysterical under these circumstances” (Pellens and Terry 1970: 599). Female drug addicts had inherited the unpredictability and poor temperaments from their “hysteric” counterparts of the previous generation (Tasca et al. 2012).

Not only were the temperaments of female drug addicts deemed more difficult than those of their male counterparts, the work of treatment entailed inciting them to different kinds of preoccupations and daily habits. M. Mignard, a French physician writing on the problem of *toxicomanes* in 1924, felt that drug addiction was primarily a moral affliction that demanded “moral medication against despair and discouragement” (Pellens and Terry 1970: 587). Part of the necessary treatment, therefore, was a re-educational period with physical labor at its core. As he argued, “Is not the overcoming of the indolence the destruction of one of the deepest mental roots of drug addiction? The work chosen must be work adapted to the means, the tastes, the condition of the patient... In the way of manual labor, work in the field or garden generally gives good results for men, household duties for women.” The most salutary environment for women was the domestic sphere, where assiduous labor would turn women away from the indolence and vice of drug use.

Yet interestingly, the household sphere was also invoked to show that women’s drug addiction was not mutually exclusive from the fulfillment of normative female roles and social obligations. The physician and addiction researcher Lawrence Kolb observed in his study of 119 cases of women addicted through medical practice: “A widow, aged 66, had taken 17 grains of morphine daily for most of 37 years. She is alert mentally but is bent with age and rheumatism... however, she does physical labor every day and makes her own living” (Lindesmith 1947: 38). The sociologist Alfred Lindesmith read Kolb’s report as an indicator that drug use was not,

contrary to popular opinion, a contraindication to “useful and productive lives” (ibid). Upper-middle class women, in this case, were held up as examples of competent, high-functioning drug users who continued to ably perform their reproductive and domestic functions; they were increasingly held up as foils against younger men (and women) who used heroin obtained from the street.

Wealthy women also were able to obtain treatment in private, cash-based treatment in sanitarium-style facilities. The famous Keeley Institute, for example, founded by Dr. Leslie Keeley in 1879, marketed itself at providing discreet treatment options for alcohol, opium and cocaine (White 1998:50). At the Institute based at Dwight, Illinois, female patients were housed in separate quarters and sequestered from public exposure and from the male patients; housewives, as well as physicians, farmers, clerks, lawyers and mechanics comprised the majority of occupations of patients in the Keeley logbook from 1900. The women received the same exact treatment as the men—the much-touted “Double Chloride of Gold” cure – said to be effective for all kinds of addiction.

Drug Maintenance Clinics and Shifting Paradigms of Drug User as Criminal

The rise of the availability of heroin on the street and the decline in the availability of other forms of opiates after the passage of the Harrison Narcotic Act of 1914 would change the way that both women and men procured drugs and maintain addictions.⁴² Notions of psychological and sociological deviance (particularly Lawrence Kolb’s categorization of five types of addicts) differentiated between certain kinds of addicts, drawing upon existing moral

⁴² The Harrison Act was an “to provide for the registration of, with collectors of internal revenue, and to impose a special tax upon all persons who produce, import, manufacture, compound, deal in, dispense, sell, distribute, or give away opium or coca leaves, their salts, derivatives, or preparations, and for other purposes.” For more information on the passage of the Harrison Act, see Musto 1987: 54-69.

sensibilities.⁴³ Women were seen as mostly “Type 1,” or as those “necessarily addicted in medical practice,” but they would increasingly belong to other types (including pleasure-seekers, Type 2, and habitual criminals, Type 4) in the wake of the Harrison Act. As Cuskey, Premkumar and Siegel have argued, the Harrison Act was the “watershed event that started the change that was to affect the entire complexion of American drug control and the pattern and extent of female drug abuse” (1970:12). After Harrison, it was increasingly difficult to obtain opiates from physicians or druggists and both women and men turned to the streets—the so-called “underworld.”

Yet there was a brief time where it seemed possible that individuals with opiate addictions might be able to procure drugs legally and safely. From 1919-1923, approximately forty heroin maintenance clinics (operated by physicians at the initial urging of the Institutional Revenue Service) around the country were promoted as a potential solution as drug addiction was associated with increasing crime. Women comprised a significant part of the population of these narcotic clinics: the Worth St. Clinic in New York City had registered 7,464 addicts in January of 1920, including 1,600 women (Musto 1999:158). Federal drug enforcement investigators policed these clinics often, convinced that the clinics were giving opiates to people who were not genuinely addicted and physically “sick.” As David Musto recorded from the agents’ original reports, the women looked too healthy: “‘Mrs. S—36 years old, 8 years an addict, received 10 grains daily.’ She appeared to the agents as ‘a good healthy plain everyday drug addict,’ not ill but ‘the picture of health; strongly built, and to our minds is a simple vicious addict’” (Musto 1999:171). These young female addicts were associated with the “underworld” immorality and were subsequently deemed undeserving of medical treatment of addiction.

⁴³ Kolb’s (1925) classification included five types: Type 1) Normal individuals accidentally or necessarily addicted in medical practice; Type 2) Carefree individuals devoted to pleasure seeking new sensations; 3) Definite neuroses 4) Habitual criminals—always psychopathic and Type 5) Inebriates.

Lexington Narco Farm: Emerging Gendered Treatment Paradigms in Prison Treatment

The ascendant social response to drug addiction had meanwhile become criminalization and institutionalization, with violators of the Harrison Act increasingly ending up in prison and jail systems that were ill-equipped to handle withdrawing drug users or to provide them treatment. In response, Congress passed the Porter Act in 1928 to allow for the creation of a new kind of institution, the “narcotic farm,” a hybrid of treatment and research facilities for addiction that might ostensibly ease the burden on other facilities (Acker 1997; Campbell, Olsen, and Walden 2008). The two new facilities run by the United States Public Health Service were based out of Lexington, Kentucky and Fort Worth, Texas.

Women were allowed into the Lexington facility in 1941; from that time, they made up 18% of total admissions, some 14,866 admissions (Cuskey, Moffett, and Clifford 1971). It was one of few places that women could get treatment and subsequently had a wait list; as Harry Anslinger, the longtime United States Commissioner on Narcotics, noted, “Only the institution in Lexington has facilities for females, consequently, women usually must wait for a short time” (Anslinger and Tompkins 1953:239).

Not only did women have to wait longer for treatment, they also were excluded from participating in existing federal addiction research. In the Lexington research wing known as the Addiction Research Center, only men were allowed to volunteer for experimental research. This research, much of which was foundational for future studies of addiction and addiction treatment methods, explicitly prohibited women from participating. Addiction researchers thought women to be unreliable self-reporters of their internal states and feelings, unlike the men. As the historian Nancy Campbell detailed, “By the late 1950s, administrators perceived voluntary patients as thorns in their sides, regarding women housed in the “Jenny Barn” as especially

troublesome... Women were not used in research, for they were considered “unreliable” subjects or worse” (2007:58).

Women were kept in strictly separate facilities at Lexington and were perceived of as primarily distractions to the men. One of the few first-hand accounts that captured the experience of women at Lexington was from Janet Clark, whose 1961 autobiography recalled her life in the “underworld.” Clark drove down from Ohio with her husband to “attempt the cure there.” It entailed a mandatory withdrawal period of hospitalization for eighteen days. She recalled that there was nothing to do during those days but talk to other addicts about heroin: “What can you do? You can only take so many baths a day, and you’re weak. I mean, that was at least a diversion, you know and there’s nothing to do—nothing—except talk about junk” (1961:216).

A more famous visitor to Lexington was the singer Billie Holiday, who was there in 1940. She confirmed Clark’s description of the lack of “treatment”: “There was no cure. They don’t cut you down slow, weaning you off the stuff gradually. They just throw you in the hospital by yourself, take you off cold turkey and watch you suffer” (Kandall 1996:103). In fact, during the withdrawal period, patients received only hot baths during the day and a sleeping pill at night. The lack of medications to help ease withdrawal symptoms at Lexington was surprising, as physicians had long known and debated over which medications would best ease the well-known symptoms. Perhaps Lexington, with its hybrid population of both “vols” and “cons,” was reflecting a new punitive turn.

After the physical detoxification, Clark insisted to her providers that she needed to see a psychotherapist, having seen one occasionally in the community. The treatment providers laughed and responded, “Well, in three or four months, or maybe five, we might be able to do something for you” (1961: 229). Clark’s experiences of and expectations of psychotherapy

reflect the predominance of this treatment modality for addiction, yet psychotherapy was withheld from Lexington patients under the premise that the short-term patients did not possess adequate “level[s] of emotional maturity” to sustain intensive psychotherapy (Anslinger and Tompkins 1953: 256). They were woefully understaffed at Lexington; the drug historian William L. White noted that “only about one fourth actually had individual psychotherapy” (1998: 124).

A main part of the treatment at Lexington was “milieu therapy,” or engaging in various kinds of labor as treatment, including growing crops, animal husbandry, chores, vocational activities, and group and individual therapy meetings. Clark herself graduated to mopping the facilities until she signed herself out against medical advice and relapsed to heroin use with her husband within several days (Clark eventually died of a barbiturate overdose). Actually what “treatment” entailed at Lexington was open to contention; in reality, the Lexington hospital provided a relatively safe place to detox from opiates but they did not actually address the underlying sociological or psychological factors behind patients’ pathways into addiction.

Women continued to cycle back to Lexington. As Cuskey et al. (1971) pointed out, between the time period of 1961 and 1967, four out of every ten admissions of female addicts was a re-admission.⁴⁴ Cuskey and his colleagues worried about the “treatment effectiveness” and the “cost effectiveness” of the Lexington program but also what they called the “social costs” of female drug addiction, including:

damaged self-image; deterioration of personal health, productivity and creativity; personal degradation from criminality and prostitution; high death rates; family disorganization with the resulting damage to the marriage partner, the children and extended family members; and aggression against individuals and their property, producing a climate of general insecurity (1971: 338).

⁴⁴ This rate of relapse was not significantly higher than that of their male counterparts at Lexington. M.J Pescor suggested that about 30% of addicts at Lexington were abstinent after three years of release (1941:1419). Hunt and Odoroff (1962) found that more than 90% of addicts treated at Lexington who returned to New York relapsed.

They were specifically concerned with the plight of young black children of drug users, whose “socialization needs... living in pathogenic or pathologic situations” demanded attention; this was especially true for “female children, especially Negro, whose life alternatives are generally limited to their immediate family and its social network” (1971: 337).

Clark personally claimed to have observed a difference in two types of female addicts at Lexington in 1941: those who belonged to the underworld (like herself) and those who were primarily “medical addicts.” Clark considered herself to be of the new generation of self-proclaimed junkies who could not maintain middle-class aristocratic pretensions. As Cuskey, Moffett and Clifford (1971) noted, 92% of the younger women in Lexington admitted to frequent contact with the “drug subculture,” while among women older than 37, only 41% reported they involvement with the “underworld.” These older women might have been able to avoid contact with street narcotics given the willingness of physicians to continue to discreetly prescribe opiates in their medical practices. More and more young African-American women began to be involved in heroin use.⁴⁵ Yet researchers viewed the heroin use among young black women as a fact of living in poverty and vice, while heroin use among young white women was instead seen as an avoidable and unfortunate tragedy.

MCI-Framingham: Historical “Treatment” of Deviant Incarcerated Women in Massachusetts

While the research conducted at the Lexington facility set the tone for the national conversations about addiction, local facilities also were attempting to address the problem of drug use, alcoholism and addiction within their institutions. In Massachusetts, the sole women’s

⁴⁵ Before 1950, 10% of black addicts at Lexington were female and the figure doubled to 25% by 1955. Black women represented 1/3 of the female admissions to Lexington by 1965 and ½ of the admissions in 1967 (Cuskey, Moffett, and Clifford 1971; Chambers, Hinesley, and Moldestad 1970).

prison—originally known as the Reformatory for Women in Sherborn—conceived of drug treatment within the context of rehabilitation of deviant women more generally. What kinds of treatment philosophies and paradigms operated within the prison and how and why did these approaches change over time? Was there any evidence suggesting that these orientations “worked”—that is, rehabilitated women to lives free of crime? Were women seen as different kinds of offenders than their male counterparts? What was the exact relationship between poverty, drug use, crime and the prison, and what, in fact, could the prison do about any of it?

Prisons struggled to define what “treatment” actually entailed. As the Warden of the State Prison in Charlestown, wrote in 1951:

The responsibility of the State Prison extends beyond that of mere custody. We must make every reasonable effort to reform and improve the inmate so that upon his parole or discharge he may take his place among his fellow men as a self-respecting, law-abiding citizen. We have a social obligation and we protect society only insofar as we readapt the inmate to social life so that he will give up his criminal ways (McDowell 1951: 14).

John Gavin, one of the superintendents of Walpole, urged treatment as a concern of the whole prison, or “the involvement of all personnel in all institutions in the overall problem of Treatment, keeping in mind that our version of Treatment means everybody’s job who comes into contact with an inmate from the time of arrest through trial, conviction, confinement, release and restoration to full citizenship” (1963: 9-10). Treatment, therefore, was actually conceived of in a broadly holistic way and both men and women were seen as reformable, capable of positive change.⁴⁶

⁴⁶ There was a widespread sense that incarcerated men and women were going to return to their communities and that physical and mental cultivation of individuals was important. Inside the male facilities, men enjoyed taking Harvard classes, playing Bocci ball, and participating in debate leagues. The Norfolk debate team famously debated Ivy League institutions and other institutions of higher learning such as Oxford University and McGill (for example, in 1951 Norfolk debated seven academic institutions, including Harvard University on February 11—“That the American people should support the Welfare State.” Norfolk had the affirmative” (Annual Report of the Commissioner of Corrections 1951:31).

The Reformatory for Women in Framingham (also known as Framingham State Prison and later as MCI-Framingham) is one of the oldest physically intact correctional institutions for women in the country. Designed by the architect George Ropes in 1877, Framingham was conceived of within the specific reform tradition in the late nineteenth century that believed that the female offenders should not be treated in the same fashion as male offenders. Prior to this, women were generally held in local jails that also held men. Women in these mixed facilities, given their small number, tended to receive terrible treatment and live in squalid, neglected parts of the prisons. They were generally seen as distractions to the work of incarcerating men or just as downright trouble: in the words of one prison official in Illinois, “One female is of more trouble than twenty males” (Dodge 2002: 29).

The Reformatory for Women was the product of the upper- and middle-class reform advocacy efforts by women who had been involved in other kinds of social crusading movements, including abolitionism and the social purity movement (against prostitution, then called “white slavery”). Nationally, prison reformers decided in 1870 that they “should treat rather than punish” (Rafter 1985:235). The prison reformatories for women focused on treatment and moral education for poor and working-class women at the hands of their upper-middle class counterparts—“through sisterly care, counsel and sympathy of their own sex” as prison official Zebulon Brockway of the Detroit House of Corrections said (Rafter 1990:26). The dominant correctional and legal philosophy at the turn of the century was the indeterminate sentence. Brockway pioneered this in the state of Michigan with women convicted of prostitution, and he convinced the Michigan legislature to hold prostitutes for up to three years “on the theory that with retraining, they might be reformed” although the legislature would not apply the legislative principle to men in the state (Rafter 1990:25).

Women were therefore were held in reformatories for longer periods of time for even milder offenses than men. Nicole Rafter writes that such a move legislated a double standard: “In particular, they hoped to redeem women who had not sunk into the pit of confirmed criminality but as yet teetered on its brink... not with the female felons held in custodial prisons but with a group not yet subject to state punishment—vagrants, unwed mothers, prostitutes, and other “fallen” women who seemed more promising material for their attempts to uplift and retrain” (1990: xxviii). In Massachusetts in the 1880s, a woman convicted of drunkenness could be held for one to two years while a man convicted of drunkenness could only be held for up to one year; the reasoning was that “lapses in morality were more serious in women than men, and women, needing more protection, deserved more treatment” (Rafter 1985: 238).

Women in Massachusetts were historically incarcerated for three overarching categories of offenses: offenses against persons (such as assault, manslaughter, murder or robbery); offenses against property (e.g., arson, breaking and entering, forgery, larceny); and offenses “against public order.” This third and last category comprised the majority of total offenses (90% during the 1930s and 1940s), and included crimes such as “abortion,” “adultery,” “being a lewd, wanton and lascivious person in speech and behavior,” “drunkenness,” “escape,” “fornication,” “idle and disorderly,” “lewd and lascivious cohabitation,” “violating narcotic drug laws,” “nonsupport,” “stubbornness,” and “unnatural acts” (1946 Annual Report: 114-115). These were offenses that largely violated conventional middle-class morality; the chief offenders were poor and working-class women who could not easily conform to ideals of domestic purity and femininity. In 1947, there were eleven women “charged with stubbornness and sentenced to 2 years indeterminate sentence.”

Philosophies of reforming these women stressed femininity and imparting beauty, grace and hope to fallen women. As the historian Estelle Freedman noted, “[The reformers] offered a vision of rehabilitation through maternal uplift, in bucolic, cottage-style reformatories that offered a strong dose of domestic training” (1996:185). Women were meant to be reformed rather than punished, and the cottage architecture in which women were kept was intended to correct “the dearth of beauty and graciousness in the lives of so many of our youthful offenders” (Smith 1959:6), although many women still perceived of these cottages as prison and “cannot control their impulse to escape” (Smith 1961:25). As Foucault has famously written about the physical design of prisons, this was “an architecture that would operate to transform individuals: to act on those it shelters, to provide a hold on their conduct, to carry the effects of power right to them, to make it possible to know them, to alter them” (1995:172).

Equipping the women with educational opportunities, home-making skills and the benefits derived from physical labor were thought to be essential to the moral rehabilitation of the prisoner. Most of the state prison facilities had farms and industries such as power plants, flag-making, and other endeavors that made a profit for the facility; prisoners provided much of the labor that ran the actual day-to-day operations of these institutions. Women in the reformatory often worked as servants in local towns, training for lives in domestic service. The labor of incarcerated women in the community (the “day indenture” program) was controversial for Van Waters, but Superintendent Betty Smith continued her predecessor’s program, noting they had over 500 community employers. She felt the program helped the women, arguing that “day work is a vital rehabilitation step before returning to the community. It is an excellent therapy for our girls to observe how well homes function in the community...” (1960: 5).

Parole, or conditional release to the community with the threat of revocation and subsequent re-incarceration, was also an integral part of indeterminate sentencing. In 1950, women who were on parole had their parole revoked for reasons such as failing to report (“whereabouts unknown”) but also “leaving home, work or state without permission, drunkenness, indiscreet conduct, failure to adjust” (McDowell 1950:101). Ongoing prison surveillance and power therefore extended into the “free” lives of women who had been marked as criminals, enmeshing them in the prison system.

Overall, treatment for incarcerated women was geared towards helping women to conform to conventional social norms via “character retraining” (Freedman 1996: 186). There was also a strong sense that women who grew up in relatively deprived social and family conditions were in need of being “saved,” and there was optimism that spiritual uplift and exposure to proper habits could turn these deviant women around. Miriam Van Waters, who presided over the Reformatory for Women for three decades as the Superintendent, had “great faith in the salvation of individuals... even a girl ‘who has given herself to many lovers, has suffered disease, abandonment and rough handling’ could become a ‘healthy, charming woman, devoted to children and husband, if she could lose her delinquent identity’” (Freedman 1996: 128). Thus, the goals of treatment in this facility tended to conform to these highly stereotyped, upper-middle class gender roles in which the ideal woman was a homemaker, a mother, and a wife.

For the women, this meant that much of their treatment was conducted in small, unlocked cottages where inmates lived. In addition to taking classes on the “homemaking arts” at their cottages and learning how to sew and cook, they had group psychotherapy. The cottage architecture was designed to create a healthful milieu for the young women based on the goals of

seeing “each girl as an individual and whole person, for whom the open cottage situation might serve as an emotionally maturing, vocationally useful, and socially enriching experience in terms of the coming, broader challenge of the outside community,” as the Superintendent Betty Smith wrote (1959: 5).

Within the Framingham cottage facility, there was a separate “drug addict department” that contained both voluntary commitments and those committed by the court for drug addiction as well as “inebriation.” Much like the federal treatment facility in Lexington, Framingham had a system that allowed for the treatment of both voluntary and mandated women, although they certainly intermingled with women charged of other offenses. Men who were criminally committed with drug addiction and/or alcoholism were sent to a state facility within a prison at Bridgewater, Massachusetts, known colloquially as “State Farm” (Bridgewater was then composed of three separate populations: the Drug Addict Department; the Male Defective Delinquents; and the Criminally Insane). Yet the number of women committed to the Drug Addict Department at Framingham remained in the single digits throughout the 1940s, 1950s and even through the 1960s. In 1949, for example, there were 2 prior drug addict commits, 3 new commits (from the courts) and 3 new voluntaries; among the “inebriates” (alcoholics), there were 2 prior commits, 10 new commits and 5 new voluntary commits (Waters 1949: N.P.).

These early enmeshments of drug use and alcoholism with the prison itself presaged the re-siting of addiction treatment into the space of the prison in the 1970s. And while there were violators of narcotic laws and women dealing with alcoholism or drug use in these preceding decades, there was not a specifically outlined program for caring for them. There was even some doubt as to whether the prison was the appropriate place for treatment for this population. As superintendent Miriam Van Waters told a reporter in 1935, “More than half the people here

should not have been sent here. There are chronic alcoholics. To send them to prison is absurd. Likewise prostitutes” (Freedman 1996: 190). The question of how to rehabilitate these men and women who drank too much or used drugs was in some debate. In a letter from Commissioner of Corrections Elliott McDowell to the Massachusetts State Legislature, McDowell wrote that he believed that “the rehabilitation of this type of offender... primarily needs medical care” (1951:7).

Psychotherapy and the Rise of the Pys: The Division of Legal Medicine

The 1950s was a decade largely defined by prison-based ‘treatment’ that was influenced by the rise of the medical, social work, and psychological professions. In 1951, Miriam Van Waters wrote in her Annual Report that they had restored the “program for treating alcoholics...based on the co-operation of various research centers, clinics, the Boston Comm. For Education in Alcoholism, the Alcoholics Anonymous, and our own Staff of Psychologist, Psychiatrists, Social Workers, and Group Therapists” (1951:57). The clinic for drug addicts and alcoholics at Framingham was primarily centered around psychotherapeutic techniques as well as providing social support upon release. The State Farm at Bridgewater was experimenting with a new promising psychopharmacological treatment for alcoholism known as Antabuse therapy upon release from prison for male prisoners, but no such program was started at the women’s facility.⁴⁷ The Psychiatrists at State Farm also introduced a new antidepressant, thiorazine, and initiated electro-convulsive therapy, albeit infrequently utilized.⁴⁸

⁴⁷ Interestingly, they found promising results with Antabuse trials: “Of the total number admitted to the State Farm for Alcoholism, 301 were referred for further help, either to public clinics (8 cooperating), a private clinic (1 cooperating), or to private physicians (5 cooperating), for follow-up therapy. Of these, 70 were found physically fit for Antabuse and were started on this drug one week before leaving the State Farm. Only 29, or 41.4 per cent, of this group, found it necessary to return to the State Farm for further treatment, while the average rate of recidivism of the alcoholic population here has been approximately 80 percent” (Leurie 1953:115). This is a novel incidence of the

Both the facilities for women and men struggled with creating a program that could successfully rehabilitate drug addicts and alcoholics and prevent the revolving door of these individuals in and out of state institutions. This reflected more general epistemological uncertainty about etiologies of drug addiction as well as controversies about optimal treatment methods. As the Warden of State Farm at Bridgewater wrote in 1951:

The rehabilitation of inmates is one of our greatest problems. To train the individuals to resume their place in the community, to earn a living, to join an Alcoholics Anonymous group, to continue their religious affiliations, is part of the pattern, and our personnel strive to achieve the desired results, even though we are handicapped by the need of physical facilities. Unsatisfactory family relationships and the inability or the unwillingness of the individual to cooperate is a deterrent to our aims.

In 1955, there was a concerted attempt to develop what prison officials called a “treatment oriented program within the department of correction” (Spurr 1955). This entailed recruiting professionally trained social workers, psychologists, and psychiatrists into the prison staff as well as “bringing treatment and custodial personnel closer together.” As the Warden of State Farm wrote in the annual report to the Commissioner of Corrections: “It is hoped that through the use of Chemotherapy and Group therapy, it will be possible to rehabilitate more patients to the degree where they can be integrated into useful community life” (1955: 6).

With psychotropic medications for mental illness in its infancy, “chemotherapy” was limited. Putting a patient-inmate on a medication for life was simply not a paradigm of addiction treatment. The medicalization of deviance would grow as the anti-depressants and mood stabilizers became more frequently utilized in community settings. Instead, the mainstay of the prison treatment program was largely oriented by psychotherapy and social work. Following

prison actually initiating medical treatment before release of individuals in their care with follow-up in the community.

⁴⁸ Superintendent Jeremiah Dacey of MCI-Norfolk noted, “Even the so-called tranquilizer are rarely used except on the recommendation of the psychiatrist.... At present, we feel it is unwise to use them as wholesale until such time as their place is well-defined” (1957: 20).

success of a psychiatric treatment service at two men's facilities, a program called the Division of Legal Medicine was expanded to MCI-Framingham in 1955. According to the Department of Mental Health, the Division of Legal Medicine "furnishes psychiatric services to the courts, the Department of Correction, the Youth Service Board and other state agencies which deal with such major social problems as crime, juvenile delinquency, sex crime, drug addiction and alcoholism" (1958: 14). At MCI-Framingham the Division of Legal Medicine had implemented "a case work program and a classification committee."

Norman Neiberg, PhD, a clinical psychologist who founded the Department of Legal Medicine at Framingham in the 1950s and remained there for several decades, recalled that the women's prison at the time was "not like the prisons now...the schism that you usually see in male institutions-between we the caretakers and the hostile environment—just didn't exist."⁴⁹ He recalled that:

At the time drunkenness was a crime. And if you got soused and were a nuisance you got sentenced to Framingham for six months. During which time, we probably saved half the lives of people. Because they were well fed, they had a bed at night, they had a good doctor... So for the six months that they were there they were all cured. That's cured by not having access to alcohol.

Treatment, at the time, according to Neiberg, predominantly consisted of "food, shelter, kindness, group discussions, contact with the outpatient therapist, and a lot of contact with the in-house social service staff at Framingham." Neiberg, trained in the psychoanalytic orientation as it was in its ascendance, was convinced that individual long-term psychotherapy and group psychotherapy were critical to the short- and long-term success of these women, but that meant that the treatment team was routinely stymied once a woman left the facility. Importantly, the prison could provide the basic needs of women that often were not met when they were on the streets. The effect of being removed from a pathological environment was in and of itself what

⁴⁹ Norman Neiberg, PhD, interview by author, Newton, MA, November 9, 2012.

“saved” most women, rather than any treatments, kindnesses or moral uplift that they may have experienced while incarcerated.

One of the main “treatment” problems, therefore, was the relative inability of the prisons to establish a continuum of care that would help assist the inmates upon their release in dealing with the structural conditions of their lives that often contributed to their incarceration in the first place. Neiberg create a system for continuity of care across the prison into the community; he organized physicians doctors from the Peter Bent Brigham Hospital to staff two-half day sessions a week to treat the alcoholic women at MCI-Framingham, hoping to establish a continuity of care and rapport to engage the women in treatment. Yet the treatment team was stymied by the general refusal of the majority of women to attend the community-based clinic; as the superintendent of Framingham in 1957 reported, “There have been 84 released and each has been referred in compliance with the law. The Clinics are asked to report to us when women report to the Clinic and only three so far have reported attendance at the clinic” (1957:1).

The prison staff felt that they needed to do more for women upon their release in order to have a lasting impact: “We urge that more casework and guidance services be made available to the released alcoholic. Results from referrals to an alcoholic clinic have been almost nil. Expansion of group therapy within the Institution, coupled with clinic referral or AA sponsors who will assist in the “follow up” should be tried” (1959: 16). Another issue in the failure of rehabilitation was the problem of where women went upon their release. Thus, the halfway house developed by Friends of Framingham was seen as a critical innovation—a community-based extension of treatment initiated in the prison: “The Treatment program coupled with help from the community and the Half-Way House should be a real boon to the woman who is seriously interested in maintaining sobriety” (Smith 1963: 12). Neiberg offered the services of the Division

of Legal Medicine to “supply case workers and group therapists and assist in the screening of girls released to the house and thus continue in the community the treatment started in the institution” (1962: 2). Ten years later, it was not clear that the Friends of Framingham halfway house in Dorchester was “successful”; a newspaper profile piece on the halfway house noted that of the 45 women who had stayed at the halfway house in two years “although there are no hard statistics, the number of women who have successfully completed the program is limited” (Kirchheimer 1972). They attributed the general lack of success to “working with the people with the most problems.”

Heroin addicts and alcoholics often returned to prison or jail. Women who drank comprised over half the total admissions to the prison in 1960 (“drunkenness”) and the prison hoped to “expand this [group therapy] program, to include some occupational skills, training, more groups and individual therapy, to an AA Sponsorship and help in obtaining room and jobs upon release” (Smith 1960:2). Neiberg recalled that the heroin addicts were particularly recalcitrant and were frequently re-institutionalized. He established long-term relationships with them as they cycled in and out of the institution.⁵⁰ While he was unable to recall any exact numbers, he remembered that most of the heroin addicts at the time tended to be African-American, while most of the alcoholics were Caucasian (the Annual Reports did not record race but rather state of origin as well as the country of origin of the mother and of the father).⁵¹

⁵⁰ Neiberg recalls that one of his patients from the prison recognized him in the community while he was courting his wife and strolling with her down the streets of Boston in the Bay Village area on a date. She screamed his name out excitedly and said hello, baring her breast and hanging out of the window of one of the nearby apartment buildings.

⁵¹ Historian Estelle Freedman confirms that there was a shift in racial composition in the prison population in Northern states around 1960, given the “renewed migration of African-Americans during World War II, combined with persistent economic and social discrimination against them...the growing proportion of black prisoners in the North, along with racial stereotypes of Blacks as less moral than Whites, weakened support for prison reform [in Massachusetts]” (1996: 318).

Neiberg recalled that most of the women who came to the prison for heroin addiction did not actually enter by officially violating narcotic drug laws, but more commonly for prostitution or petty larceny. He characterized heroin addicts as tough, smart survivors, growing up and surviving in inordinately harsh circumstances: “Most of these people were born with one chance in ten of making a good live for themselves, born behind the eight ball, through no fault of their own.” He became convinced that the only formula for effectively treating these women was to encounter them inside and then “hand hold” them outside. Having a good therapeutic relationship, a safe place to live (he cited the newly formed halfway and three-quarters way houses), and finding a job were all imperative for the success of women leaving prison. He lamented that if you “take any one of those away and it goes down the tubes.”

To address the complexity of these issues, the prison’s Social Services Department multiplied and the kinds of data kept on offenders (classifying, charting and organizing different types of criminals) increased drastically in the 1950s and the 1960s. As the Superintendent of MCI-Framingham, Betty Smith, wrote in 1960 in the Annual Report, “Of course, the heart of the treatment program lies in the Social Services Department” (1960: 8). The staff at the social services department made efforts to document numerous characteristics about the inmates, even taking “occasional field trips to patients’ homes either to gather data or help solve some of their community problems” (Warren 1953:7). The prison staff wondered if the “treatment” philosophy and care that the “girls” received in prison translated into desirable outcomes upon release. Yet they found it difficult to actually measure outcomes; as Smith wrote, “It is at the present time not possible to measure the effectiveness of our program in terms of a decrease of recidivism rate of people that are in treatment and those that are not in treatment. We are at best only one factor involved in the social controls of these persons when they leave the Institution” (1960: 18).

This was a period of intensive subjectification of women in prison. Their lives became case studies of wayward femininity for the prison social workers; the prison was “a sort of permanent observatory that made it possible to distribute the varieties of vices or weaknesses” (Foucault 1995:126). Prison officials and social scientists strove to assess “the potentiality of danger that lies hidden in an individual” (ibid). But it was more than just the treatment staff that were responsible for observing and changing untoward behaviors, it was the entire operation of the prison and staff at all levels. As Smith wrote:

It is becoming increasingly recognized that all members of the institution staff have an impact on this process we call rehabilitation—on the reconstruction of behavior patterns of inmates: “It is the day-to-day living, the total prison community, which militates against or fosters correction. It is not solely the responsibility of the “treatment staff” although they do act as the spearhead, but it is the total system, the total environment that must be brought to bear upon modifying and revamping the women offenders’ unacceptable behavior patterns.

If a prison is to be truly a corrective institution we must then maintain a healthy climate, we must make use of all the techniques and “know-how” of social work, psychology, education and recreation, and what we must provide for the vocational training as well. The important intangible is [the] relationship... (1963:2).

Psychotherapy was a key orienting principle to both assessing/known criminal women and treating their criminal thinking and behaviors; it was, in many ways, the foundation of other methods of rehabilitation. In 1959, a psychotherapy group was institutionalized under the guidance of the psychiatrist Eliot Baker at Hodder Hall, one of the cottages for youthful female offenders. The Division of Legal Medicine also conducted its own group therapy programs for new inmates at intake and throughout the cottages. In 1962, Neiberg wrote that “at any one time we have approximately 30% of the institution in one kind or another psychotherapy” (1962:15).

Interestingly, group therapy was even mandated as a form of discipline and punishment for those who were deemed “chronic troublemakers.” Neiberg wrote that the “rash of disciplinary problems within the institution” warranted mandatory group therapy meetings and he thought they seemed to be “from a clinical point of view... promising” (1962: 16). Yet the treatment staff just could not seem to achieve the benefits from holistic therapy and long-term

psychotherapy that they hoped for. For example, the women who came to MCI-Framingham on cases of “drunkenness” stayed, on average, six months. Superintendent Smith felt stymied by the short length of prison sentences that could not achieve anything meaningful with women that were extremely “damaged by the time they come to us”:

I feel that one definite element constantly appears as a hindrance to the most effective program of rehabilitation; the length of stay of the younger inmates seems cruelly short. These people are, in general, so damaged by the time they come to us that they need an extended period of time under control before they can develop any meaningful relationship—be it to psychotherapist or correctional institution (1961:20).

The problem, therefore, was shifting away from the internalized deviance within the women themselves to their abnormal attachments or inability to have healthy relationships. There is also evidence that the inmates did not view the correctional treatments as favorably as the staff did. James Warren, the Warden of State Farm, wrote in 1954 that the rehabilitation clinic was possibly being abused by the inmates: “It is becoming evident that some of the inmates use the [Rehabilitation] Clinic as a means to early release rather than as a means towards rehabilitation” (1954:67). One of the reports from one of the Framingham cottages, Wilson Cottage, noted that the “clientele ... is a lethargic group, with inner seethings rather than healthy outer aggressions” (Smith 1963: 41). The women appeared lackluster in their participation in treatment regimens.

This was overall an era of optimism and faith in both the science and processes of rehabilitation. In 1951, the chaplain of the Men’s Reformatory at Concord wrote that “the reformation of social bad habits is not only possible but very practicable.” The prison officials and community volunteers believed in their efforts wholeheartedly; as Mary Clary, the Director of Hodder Hall (one of the Framingham cottages), wrote in 1962, “If there is no accurate yard stick by which to measure lasting rehabilitative results from the foregoing projects, there is no doubt as to their immediate good. To plant a few seeds of referential potential and pleasure, to soften hardened concepts of authority and society, *to separate the sexes into their normal roles*,

to give off a sense of personal worth and hope; these do count for something. They make, in fact, the difference between lethal custody and the truly therapeutic milieu” (1962: 21; italics added).

Thus, a gendered form of treatment and punishment slowly became enmeshed in the prison system for wayward women, particularly those who used heroin and alcohol, even though they were relatively small in numbers. The difficulties the prison had “treating” these women reflected the still relatively sparse community treatment alternatives prior to the medicalization of opiate addiction treatment. They tried to create a “therapeutic milieu” by gifting beauty, grace and seeds of pleasure and joy and self-esteem but there was little direct recognition of women’s trauma or their paths into the prison. Addiction was seen as within the purview of prison mental health programs that had been dominated by psychotherapy yet was more increasingly involving tranquilizers and anti-depressants, or “chemotherapy.” Community options for drug treatment slowly emerged, becoming more widespread with the increasing presence of Alcoholics Anonymous in local communities in the 1950s, Narcotics Anonymous in the 1960s and the burgeoning residential self-help movement.

The problem of “treating” women in prison revealed a variety of at times irreconcilable differences in both treatment paradigms and practice. Smith’s 1959 Annual Report notes their efforts at creating “an atmosphere... more conducive to getting on with the business of rehabilitation. As opposite as they both may seem, the establishment of both the Beauty Shop and Segregation Unit had good effect. In their own ways, they are perhaps symbolic of the new trend: unlimited resources for personal development; but with increasing limits placed on deviant behavior” (1959: 6-7). Punishment (“the segregation unit”) and a gendered form of vocational training (“the beauty shop”) existed side-by-side in this prison treatment paradigm for women.

Foucault notes in his classic work, *Discipline and Punish*, that the carceral system moved away from the spectacle of public torture to a hidden system exerting total control over not only the body but also the soul and the mind. Prison officials necessarily had to expand and recruit professionals in the emergent psychological, social, medial and legal fields to both study and implement these new forms of surveillance and control. As Foucault wrote, “If it is still necessary for the law to reach and manipulate the body of the convict, it will be at a distance, in the proper way, according to strict rules, and with a much ‘higher’ aim... A whole army of technicians took over from the executioner, the immediate anatomist of pain: wardens, doctors, chaplains, psychiatrists, psychologists, educationalists” (1995: 11). The recruitment of professionals served to cement the prison as a proper, necessary and moral site for the “treatment,” rehabilitation and punishment of deviance.

The Rise of Community Drug Treatment and Implications for Women

The 1960s set the scene for an enlightened, inquiring stance into the treatment of heroin addiction in particular. As the physician Stephen Kandall explained it:

The election of John F. Kennedy to the presidency in 1960 reordered national priorities on many mental health issues... Integrated into the more enlightened approach of this period was the development of many new kinds of treatment for narcotic addiction, including therapeutic communities, outpatient treatment, medical detoxification, correctional treatment programs, and methadone maintenance (1996:5).

Not only was there new leadership, there was the passing of the old guard: Harry Anslinger, who had waged a thirty-year war from the Federal Bureau of Narcotics against treating addiction as a medical condition, retired in 1962. Yet the War on Drugs that he had incited for decades now had too many tentacles in local and state bureaucracies and laws to be undone.

In 1961, the Joint Committee of the American Bar Association and the American Medical Association assessed the effects of the Harrison Law of 1914, the Porter Law of 1928, and the Boggs Act in 1951 that had effectively resulted in the criminalization of addiction. They published a joint report in 1961 entitled, “Drug Addiction, Crime or Disease?” As Morris Ploscowe wrote in the appendix to this report, new methods of drug treatment and new research advances were sorely needed: “The statistics on relapse to addiction after attempted cures at narcotics hospitals like Lexington, Fort Worth or Riverside [Hospital] tell the stark story of the basic failure of the hospital centered approach in dealing with problems of drug addiction” (ABA and AMA 1961:N.P.).

One new treatment modality, methadone maintenance, appeared to meet that need. Developed to scale by Dr. Vincent Dole, an endocrinologist, and Dr. Marie Nyswander, a psychiatrist at the Rockefeller Hospital (although investigated decades earlier at Lexington as a detoxification agent), methadone maintenance seemed to promise the potential to curb addicts’ desires for heroin and transform criminal outcasts into stable, functional people. In the 1960s and 1970s, women became very involved as patients in methadone programs.⁵² Research indicated that women on methadone gained in social stability as well as health benefits. Frances Gearing, who evaluated the program at the Beth Israel and Harlem Hospitals in New York, found that women tended to leave welfare, return to school and go back to work if they were able to stay in the program for twenty-four months (1971:171). Women made up approximately 25% of the 21,000 methadone patients in New York City during its first four years (Newman 1988:238). Methadone programs gained ground nationally, mostly through the discourse of reducing crime.

⁵² As *The New York Times* reported, Dole and Nyswander started a demonstration project with four women addicts after their initial hesitation to experimentally treat women due to concerns that methadone would negatively affect hormonal cycles (Kaplan 1965). Three years later, fifty women were included in their New York-based research group of 383 heroin addicts (Arnold 1967).

In 1971, Richard Nixon declared that methadone maintenance was “a treatment tool most productive of tangible results,” a critical component in fighting urban crime and vice (Todd 1975).

The methadone clinics seemed as if they might benefit women in particular ways that echoed the potential benefits that drug maintenance clinics of the early 1920s had provided for female addicts, such as liberating women from depending on men for drugs, preventing sex work that was traded or sold for drugs, and avoiding the negative health benefits of injection drug use. Some women reported regaining their menstrual cycles and a renewed feeling of well-being and health that came with it (Wallach, Jerez, and Blinick 1969). One woman reported that she did not have to steal as often as she had when she was on heroin, exactly the sort of results that physicians hoped would sway a policy audience (Rosenbaum 1981:118). Yet others argued that the culture of methadone clinics was dominated by and for male addicts and retention rates of women in these programs began to decline by the early 1970s (Todd 1975: 12).

Some of those who were particularly critical of the methadone maintenance approach advocated for total abstinence, a position embraced almost unequivocally by the prisons and jails. Therapeutic communities (TCs) became a widespread abstinence-based treatment option modeled after a program called Synanon, a drug treatment program that was founded in the 1950s by a recovering alcohol named Charles Dederich.⁵³ Women were initially included in the first Synanon group and were integral in the ideal composition of the group (Yablonsky and Dederich 1965). The form of therapy Synanon utilized was intensive group psychotherapy in which individuals would “confront” one another about their bad habits, behaviors and

⁵³ Maxwell Jones proposed six criteria for defining a therapeutic community: 1) “Two way communication” between staff and patients; 2) Shared decision-making 3) A “therapeutic culture” reflecting the “attitudes and beliefs of patients and staff and highlighting the importance of roles and role-relationships”; 4) Multiple opportunities for leadership in the community; 5) Decision-making by consensus; 6) Social learning. In *The Therapeutic Community* (New York: Basic Books, 1953).

personality traits that had led to addiction and lives of deviance. These methods were based on the philosophy that drug addicts were socially maladjusted, had personality disorders and had no sense of the world as rule-bound.

Even though therapeutic communities had widely published success rates, treatment effectiveness researchers noted that women were more likely to leave therapeutic communities than other types of programs.⁵⁴ In 1976, a national meeting on therapeutic communities found that “as currently conceived the therapeutic community has difficulty in providing services to, and holding, women residents” (DeLeon and Beschner 1977). Women criticized these programs for being focused on restoring the self-esteem and identities of men. In particular, they felt that the treatment approaches of criticizing and ripping apart their fellow patients’ personalities and life choices stirred up feelings of shame, guilt and victimization in women. The staff were typically all-male in therapeutic communities and some women reported having to perform sexual favors for male staff; male clients were admired for being “pimps” while women were degraded for being “sluts” (Soler et al. 1976). Women were accused of being certain kinds of addicts—the “intellectual junkie, bad mother, and hypochondriac” (ibid). Like other kinds of treatment programs, women were encouraged to fulfill normative gender roles, such as cleaning or learning secretarial skills (Cuskey, Berger, and Densen-Gerber 1977:307).

Studies of female addicts and attempts to create a model of female addiction simultaneously drew attention to the gendered aspects of drug use and its treatment but also served to enforce the notion of difference as deviance. Women deserved special attention, but much of the attention reinforced notions that women were “sicker” and more difficult to treat than their male counterparts. For example, DeLeon and Beschner’s studies of women in

⁵⁴ A study by Janet Sansone (1980) found that in a study of 641 residents in the Odyssey House TC, retention rates for female addicts went from 37% at twelve weeks to 10% at forty-five weeks (as opposed to 53% for men to 34%, respectively).

therapeutic communities found that women had more depression and tended to display on psychological testing more “externality,” or the sense that their problems had external roots or, even worse, were part of fate or destiny. In therapeutic drug treatment worlds, externality was viewed as a barrier to working on a troubled inner self that was the root of all problems; women were seen as blaming others—such as family, male friends and romantic partners, and life circumstances—for their drug-seeking behaviors and addiction.

Addressing these external sources of structural violence directly was not within the purview of treatment programs that hoped to work on the sick and deviant individual body. Women showed “a greater degree of pathology” in all areas and did not become less hostile over time as the men seemed to do; according to Cuskey and Densen-Gerber, mixed-sex programs failed because “female addicts have serious problems relating to men, including frigidity, feelings of victimization and conflicting protection needs, severe mistrust, hostility, in addition to suffering from the greater stigma accorded to female drug addicts and prostitutes by equally deviant males” (1977: 312).

New research showed that the general physical health status of female addicts was quite poor (Andersen 1980); Beth Glover Reed and Rebecca Moise (1979) argued that NIDA should emphasize check-ups, classes on gender-specific health issues, childcare, employment training and self-esteem and empowerment classes for women in treatment and prevention programs. The Women’s Health Movement contributed significantly to the awareness of the gendered suffering of female addicts within the addiction research community, and it became clear that women experienced significant health disparities. As one study conducted at Lexington Hospital showed, observed death rates for female addicts were higher than male addicts (O’Donnell 1969).

Not only did female addicts disproportionately suffer from increased mortality rates, they experienced many significant barriers to entering, staying in and completing treatment programs, including bans on allowing pregnant women to participate in programs. Yet even after programs attempted to address these issues related to women's health, child-bearing and motherhood, few of the programs were able to equip women to live independently and safely back in their home communities—much like problems that the women's prison encountered. Women who left drug treatment were more likely than men to have no financial resources or housing, poor health, civil and criminal legal issues and a small social network of non-addicts (Marsh and Neeley 1977). Yet addressing these issues took political will and time, and the overall devotion to the notion of rehabilitation faded.

Community Or Prison: Debates on Drugs and Crime

The 1970s was a period of national upheaval and serious debates over the social problem presented by drug use and drug addiction. In Massachusetts, the community discussion mirrored national discussions. With articles proclaiming that “Boston's Problem with Heroin Spreading in Middle Class Areas”—“no longer a problem of the poor and the slums three years ago” (Blake 1970)—a renewed and long-lasting moral panic about drugs began anew. The social response to drug addiction was truly fraught, and the 1970s was marked by an intensification of new addiction treatment efforts. These forms of treatment would compete with prisons as alternative means to deal with the social problem of crime and addiction (increasingly conflated in public discourse).

In Massachusetts, the belief in rehabilitation was strong in the early part of the decade: "Offenders who are punished but not rehabilitated usually commit further crimes...for their own

protection, the people of Massachusetts owe it to themselves to demand that inmates be treated and rehabilitated" (Hoag 1970:10). Yet there was dissent from within the ranks that prison rehabilitation was possible. In the greater Boston area, the controversial Republican Middlesex County Sheriff John Buckley argued that drug users did not get better in jails and he infamously traveled to London to learn about heroin maintenance programs. In 1973, he gave a talk at Northeastern University where he said, "Drug programs in 'the devil's workshop', as the public insists on nicknaming our correctional institutions, have failed." Arguing that addicts should be maintained on pure heroin at public health programs, he said, "At Billerica [jail] we've had more drug programs than any other prison in the state. Seven were started, but every one of them closed down" (Kneeland 1973).

There were increasingly viable alternatives to treatment for drug use in the community rather than in the prison. In 1964, Boston State Hospital founded a drug addiction unit, the first rehabilitation center for narcotic addicts in Massachusetts. Using methadone to detox the patients, the hospital tried to help "the vast majority poorly prepared for life" (Dietz 1967:74). A sample of 100 of the patients found them mostly to be white, the average age 23. Methadone was popular because it offer psychopharmaceutical promises of sobriety. An outpatient methadone clinic in Whittier Street in the Roxbury neighborhood of Boston recorded 50 patients a day in 1969 in contrast to "Boston's Dept. Of Health and Hospitals [unit] ... where no more than two addicts a day turned up so long as 'vague psychotherapy' and advice were offered" (Dietz 1969:F16).

Several legislative efforts also tried to address the social problems presented by drug use. Harsh mandatory minimums for both selling and possessing drugs were passed in the 1950s under the Boggs Act and the Daniels Act. The Narcotic Rehabilitation Act of 1966 was meant to

mandate drug treatment as an alternative to incarceration, but the implementation of such legislation was slow, difficult and imprecise. For Massachusetts, there was more than \$1 million for community-based drug treatment alternatives rather than prison sentences. The law was intended as a “pretrial diversion law” adding a new treatment component—namely screening for drug addiction, or “the obligation that a person so charged be informed of his right to an examination by a court-appointed physician to determine if he is also drug-dependent” (Dietz 1971a:2A). The defendants could have stays placed on their court proceedings and instead be “committed” to treatment; defendants were thus entitled to treatment for addiction.

The psychiatrist charged with implementing drug addiction screening across the state, Dr. Matthew Dumont, noted that psychiatric and judicial approaches to addiction treatment were not entirely aligned when the program came under fire. In the first seven months of the implementation of the program, only 77 people were assigned to inpatient treatment and 45 people to outpatient drug treatment; judges did not receive reports back, according to Dumont, because “all commitment are for one to two years.” Dumont felt that judges were overly concerned about finding secure institutions in the community for drug treatment, but Dumont argued “you can’t protect the community from the dangerous addict by putting him in prison... You can protect the community by putting him in prison. There should be no confusion between an institution designed to protect the community and a program to treat drug dependent people” (ibid).

It also was clear to judges, lawyers and the treatment community that mandating an individual to treatment for one to two years was just not occurring. Analysis of the program revealed “state officials have no records of who is under treatment, where they are, or even of how many individuals are receiving help” (Dietz 1971b:15). Judge Flaschner of Newton

observed that “when you commit someone to a storefront drop-in center [self-help drug treatment], you are essentially returning them to the same environment” (ibid). Judges stated there were not enough psychiatrists to do the necessary assessments, increasing the bureaucracy involved in implementing the law.

Massachusetts’ well-intentioned attempts to make community treatment available to drug users upon arrest as an alternative to incarceration floundered, and instead, many warned of the serious dangers of drug use and the need to take Nixon’s 1971 “War on Drugs” speech seriously. Heroin use itself was depicted as dangerous and contagious: “Dr. Dana Farnsworth of the Harvard Health Center... said that ‘a heroin addict is handicapped beyond all possibility of cure.’ He warned that one heroin addict in a community ‘will produce five or six others very easily’” (Harvey 1970). Carol Liston, the *Boston Globe* State House reporter, argued that the state’s addiction laws were not getting desirable results and that “drugs and crime walk together”: “The laws can send marijuana users to jail for three years and heroin addicts to jail for five years. But the laws do not curtail the steadily rising number of heroin and hard drug addicts.” She argued that an estimated 10,000 heroin addicts “must steal \$150 worth of goods a day... about \$1.5 million worth of property in the Boston area each day” (1971:27).⁵⁵

These seemingly contradictory concurrent attitudes and legislation towards drug use reflected epistemological uncertainty and social reactions against perceived disorder, more generally. While Liston argued for laws that would prevent crime and decrease addiction, House Speaker David M. Bartley testified to end prison sentences for simple possession of marijuana, heroin and other drugs, proposing 100 hours of community service work for a first marijuana

⁵⁵ At the time, these were just estimates. Researchers at Temple University in 1981 were the first to study heroin use and crimes committed to obtain the drug; they found that 237 addicts had committed more than 500,000 crimes over an 11-year-period that they were followed. The study also found an 84% drop-off in crimes when they were not using heroin (Los Angeles Times 1981).

offense and 500 hours for a heroin violation (Patterson 1971:29). It also was becoming clear that only the poorest and most disadvantaged drug users were going to jail; attorney Mark Cohen pointed out that “only ... those who cannot afford the services of lawyers who are skilled in the drug field” went to jail (ibid).

Bartley’s idea of working off drug convictions did not take root. Instead, a harsh bill was considered in 1974 in the Massachusetts House in response to stiff New York State narcotics legislation (known informally as the Rockefeller Drug Laws) with the fear that the tough law would drive New York drug dealers into nearby states like Massachusetts. People clamored for harsh penalties for “pushers,” the imagined king-pin, big-wig drug traffickers flooding the middle-class suburbs and inner-city neighborhoods alike with devastating “hard drugs.” Heroin became the iconic “hard drug,” linked in the public imaginary to criminal acts while “legal” drugs like alcohol, far more widespread in its abuse and implications for the public, were not similarly implicated. The Brockton Police Detective John DeBassio argued in favor of stricter laws: “And in spite of the debate about whether someone is a cold-blooded dealer or someone selling drugs to satisfy his own addiction, we realize that some people have to be removed from society. There are some people who are not going to benefit from rehabilitation” (McLaughlin and Wood 1974:3).

Incapacitation theory would increasingly dominate policy circles. In 1979, the shift to incapacitation rhetoric reached new heights and politicians clamored for strictness and harsh sentences. The Massachusetts Legislature considered revising the criminal code to address marked disparities in prison sentences imposed by the judiciary across the state. “The idea that we should send offenders to jail to rehabilitate them must be eliminated from our correctional

philosophy,” Sen. Edward (Ted) M. Kennedy (D-Mass), said, clamoring for harsh prison sentences: “Prisons are for punishment” (Spotlight 1979: 17).

Even though legislators knew that the size of the prison population could even double under the proposed legislation, they forged ahead with mandatory harsh sentences. Massachusetts at the time had one of the lowest per capita prison populations among the United States, but the newly elected Democratic Governor Edward King had won office campaigning “vigorously in favor of removing all judicial discretion when it came to sentencing repeated drug sellers or persons convicted of breaking and entering” (ibid.). In 1980, a stiff drug bill passed, even though the Governor’s “own correction commissioner, William Hogan, had said the state’s prisons could not handle all the drug dealers who would be jailed under the mandatory sentencing plan” (Robinson 1980:16).

A “Letter to the Editor” of the *Boston Globe* by George Luciano, then the Secretary of Public Safety for the Commonwealth of Massachusetts, noted that “the objective here is providing a certainty of punishment, not severity. Massachusetts ranks 46th in the nation in its rate of incarcerating convicted criminals. It is time that we clearly signal our intentions to would-be drug pushers and auto thieves ... that they will go to prison” (1980:12). So just as much as it was about those who allegedly were pushing drugs onto teenagers, the new law was also about guarding private property and the surety and consistency of punishing those who infringed on the rights of others. The emphasis on breaking and entering and petty crimes of property such as larceny indicated the felt threat to public safety and a sense of security.

These changing attitudes reflect what legal scholar Francis Allen has called “the decline of the rehabilitative ideal,” that is, a belief in the innate malleability of humans and in the social institutions meant to reform or shape individuals’ behaviors. As he writes, “[In the 1970s]

America reveals a radical loss of confidence in its public and social institutions and a significant diminishment in its sense of public purpose" (Allen 1981:18). It was not only prisons but "all the institutions traditionally relied on for socializing the young and directing human behavior to the achievement of social purposes" (Allen 1981: 19).

Community-based drug treatment options, once so promising, receded as the prisons gained prominence. The City of Boston refused federal funds for methadone maintenance programs and instead decided to "go it alone with a much stricter and smaller program for those committed to detoxification" in which slots were reduced from 518 to 200 slots with 18- to 24-months of counseling and a detoxification program. The City's Department of Health and Hospitals was concerned that with an estimated 8500 heroin addicts in Boston, they should only treat those who wanted to be "cured," arguing that "the crime and violence associated with drug use ... is properly a police problem, not a health function" (Dietz 1980:1). The methadone program, which had been running since 1970, didn't seem to be "working": "When methadone first came in, it was thought that making it available to addicts would cut down on crime. It didn't. The people in the drug programs continued to commit crimes. We depended too heavily on methadone to do the job," said Paul E. Robinson, director of the Office of Addiction Services" (ibid).

Only a year later, in 1981, records indicated that the number of heroin addicts was up from an estimated 10,000 to 11,000 users (Dwyer 1981). Facing 25% federal cutbacks for drug treatment programs, there were (again) fears that "heroin [use] has not been confined to the traditional marketplaces—poor, black, urban neighborhoods. Suburban white-collar residents are turning to heroin, in some cases using it as a substitute for cocaine because it is more potent and less expensive" (ibid). Those knowledgeable about the drug treatment landscape claimed that a

two-tiered treatment system had emerged; the *Boston Globe* editorial page wrote about the “double standard for addicts” wherein “the so-called ‘street user’ is more likely to be rejected as a patient and referred to a public drug program. The wealthy addict is more likely to obtain protective treatment, perhaps by referral to a private rehabilitation facility where the addict’s identity is a closely guarded secret” (Boston Globe Editorial Board 1980).

The 1980s was a time of relative turmoil for the prison system for women. MCI-Framingham was reeling from a raid by federal agents on the prison in which 200 state troopers converged on the prison to shut down an organized crime narcotics and gambling operation (Weidmann and Connolly 1982). MCI-Framingham also struggled to provide high-quality healthcare for incarcerated women, especially drug users. Healthcare provision in the early 1980s was complicated by the emergence of HIV/AIDS and the ensuing panics. The superintendent at the time, Joyce Murphy, recalls the episode of a woman who was arrested and brought to the prison in an ambulance with a police detail because “people were scared to death of her” (personal communication, 1/8/14). She was, according to Murphy, “committed for being a disorderly person”; the general public was terrified of the open sores on her body. Hysteria ruled the day. It frightened women at the prison too, who had no idea about how HIV was transmitted; Jean Trounstein, who taught English and theater at MCI-Framingham at the time, heard that “Algon... is what the inmates refer to as the “mental health” cottage and ... some of the women have said that anyone with HIV is thrown into Algon” (2001:115).

The drug treatment offered at MCI-Framingham began to subtly shift. They opened up a new “modular” building unit to house women who were detoxing from alcohol or opiates and the women began 30-day drug treatment programs that were then linked to other kinds of subsequent programming. Women who were primarily alcoholics and drug addicts were increasingly being

sent to prison according to a 1973 state law said that alcoholics and drug addicts who posed a threat to themselves or others could be sent to MCI-Framingham for 30 days of "treatment" and "inpatient care" while men would be sent to a Bridgewater addiction treatment center. A 34-year-old woman, Kathleen Neal, asserted that she "received no treatment for her disease, although the prison contends her 'needs were attended to'"; it was difficult to access treatment elsewhere, as "politicians, too, have not taken up the cause of an unpopular and powerless constituency or appropriated money for treatment," authorizing treatment but not the funds for it (Chinlund and Lehr 1987). When the state's 20-person-bed treatment center in Jamaica Plain was full, women were sent to MCI-Framingham; at least 138 women were sent to prison in 1987 (Reid 1989:52).

Treatment providers for women in prison were also in flux. External groups held contracts for running such programs, and a popular program run by an organization called Spring was cancelled in 1987 for another program run by Social Justice for Women on charges that the Spring program was marked by a "failure to serve minority black and Hispanic prisoners" lacking a diversity of treatment staff (Coughlin 1987). Defenders of the Spring program claimed "that 200 inmates a year attend drug and alcohol rehabilitation programs at MCI, and it cites success with 20 percent of that number, which is considered high in the field" (ibid). The argument about the two programs centered on differences of philosophy of treatment: Social Justice for Women emphasized health education about drugs and alcohol, and Spring had focused predominantly on alcohol. What was the best approach?

The Social Justice for Women organization also received a state Department of Corrections contract to house pregnant women with drug issues in Roxbury at the Dimock center at the Neil J. Houston House (Zinno 1988). The new program would allow for up to 30 pregnant women to stay approximately six months for treatment, medical care, parenting and drug

treatment. Such programs sought to re-site a small number of women under the prison's supervision into community-oriented treatment instead of behind bars.

1990s: Poor Treatment and Privatization in Massachusetts

Prison "treatment" and rehabilitation during the 1990s in Massachusetts reflected the leadership of the Republican Governor William Weld, who promised to reduce the state deficit, lower taxes and cut unemployment during his tenure from 1991-1997. He proclaimed that he was doing so by privatizing the entire state's prison healthcare. Privatization, is after all, a core value of neoliberalism (along with "stabilization" or decreasing government spending to balance budgets and "liberalization" or reversing price distortions). The state transferred its healthcare to a Florida-based for-profit prison health contractor called Emergency Health Services Management to care for 9,400 state prisoners. EMSA vastly underbid at \$28.7 million, promising to provide extremely low-cost care by limiting the number of outside hospital visits that inmates could attend (McNamara 1992a).⁵⁶ According to this new plan, EMSA had to reduce outside hospital visits for state inmates from 500 a week to 500 a month and EMSA would be penalized \$100 for every visit above the set quota.

For the previous two decades, prison health care was a mix of public-private initiatives; the previous contract holder was a private firm, Goldberg Medical Associates based out of Salem, Massachusetts, and Ronald Goldberg was accused of ethics violations when found to be charging the state for "lawn care and snowplowing at his home" (McNamara 1992a). EMSA then became the first private firm in the country to provide prison healthcare for an entire state, presaging shifts around the country that are now standard.

⁵⁶ EMSA also had little experience with mental healthcare, so it sub-contracted those services to a black-owned, Boston-based company called the Center for Health Development (CHD). Abruptly then EMSA terminated CHD without reason (Boston Globe Editorial Board 1992).

Under EMSA's care, the medical staff and prison guards at MCI-Framingham faced charges of negligence after the deaths of several women while in their custody. The physicians hired by the Health Services Unit by EMSA had no experience in women's health, HIV or gynecology/obstetrics. Many nurses with prison experience left after EMSA offered them lower salaries and benefits and nurses with no prison training came in to take their place. The first woman that died was 32-year-old Robin Peeler, who was in the Health Services Unit known at the time to the inmates as the Dungeon (McNamara 1992a). There was contention over the details of her death, with paramedics saying she was dead upon arrival but doctors disagreeing. She had been serving a one-year-sentence for shoplifting, a chronic problem for her (drugs and shoplifting). Robin carried a diagnosis of AIDS that she had received at a Rhode Island hospital and a methadone clinic. She was weak from detoxing at the prison.

EMSA's head physician, Dr. Henry Phipps, claimed that they did not know that Robin had tested positive for the virus. He said that she died of a heart attack or a pulmonary embolism, even hinting she overdosed on drugs: "This is a prison. I hate to say I'm a suspicious guy, but it's a concern I have." Her roommates told stories about Peeler vomiting blood in bed and others stole bread for her because it was the only thing she could keep down (they were punished for it with disciplinary infractions). The Superintendent Kathleen Dennehy said that the woman was punished for stealing bread because inmates "hoard bread and sugar to make hootch [prison alcohol]" (McNamara 1992b). Outside physicians called it a case of medical neglect but the Massachusetts Department of Corrections three days after Peeler's death claimed that all due diligence by the state had been taken.

Donna Jean Hamilton was the next woman who died, this time by suicide, under MCI-Framingham's purview. She was a 31-year-old sex worker and had told prison staff repeatedly

that she was going to commit suicide. She was in the prison for five weeks for a charge of "common nightwalking" and had been seen by psychiatric staff for suicidal ideation but was allowed to go back to general population. She suffocated less than 24 hours later. EMSA physician said that she was receiving antidepressants, but Phipps blamed the patient-inmate: "The truth is, she was not a very compliant individual, so she did not take them all the time" (McNamara 1992a: 15). Another woman, Dorothy Charvis, was incarcerated and pregnant and experienced a placental abruption and the loss of her fetus as a result. Phipps claimed that the healthcare situation was shoddy prior to EMSA's arrival.

Community groups alleged that the state's healthcare for women was shamefully bad. The Neil Houston House for pregnant women under DOC custody had 15 beds but "only five beds are occupied because the Department of Correction will not transfer women from Framingham" (McNamara 1992a: 16). The executive director of the House expressed frustration, saying, "We are running into any number of obstacles, but the main one is this punitive attitude that these women shouldn't be sent here to detox and learn parenting... after working in the criminal justice system in Ohio, I thought Massachusetts was very progressive in this area. I'm beginning to see otherwise"(ibid). After the death of Peeler, the prison had inmates repaint the unit and removed cages used for psychiatric patients. Outside doctors found that tests were routinely ordered and not done; referrals were made and inmates were never sent. Nurses could not get visits approved or ultrasounds done at hospitals. Phipps claimed "we do them here at the prison" but the midwives and nurses did not have an ultrasound machine. The relatively short lengths of stay of inmates made it easy to ignore acute sickness.

State Representative Barbara Gray mounted a campaign calling for increased transparency and sweeping changes. Harsh media stories drew attention to the "shame" and

"patient neglect" at MCI-Framingham and "a sick prison medical system." Gray asked for \$10,00 from the Governor William Weld to investigate MCI-Framingham's health services, saying, "My concern is whether or not the delivery of care was sporadic or even nonexistent" (Hart 1992:28). The correctional officers' union criticized a report written by Representative Gray, denying that guards had refused "basic medical attention as punishment" and claiming that Gray was "pander[ing] to the inmates here" (Hernandez 1992:18). EMSA claimed it was seeking accreditation from the National Commission on Correctional Healthcare for all facilities in two years but the accreditation was not an ongoing review process with no serious monitoring. It was not clear that MCI-Framingham, in particular, could provide adequate primary care—they did not even ask patients their full medical histories upon arrival. EMSA responded by hiring a public relations consultant (Hernandez 1992: 19).⁵⁷

At the same time, the prison was becoming crowded with first-time, nonviolent drug offenders serving mandatory minimum drug sentences, rising from 2 percent to 26 percent between 1990-1995. A *Boston Globe* investigative piece found that violent offenders were often serving shorter sentences than non-violent or first-time drug offenders (O'Neill et al. 1995:1). They concluded that "major drug dealers are regularly allowed to barter their way out of lengthy prison terms by prosecutors who have become addicted to drug forfeiture money and the use of dealers and informants" and that "hundreds of first-time offenders, many with no prior criminal record or histories of violence, are languishing for years in high-security state prisons, some locked away form 10 and 15 years with no hope of parole" (ibid). Men convicted of rape and armed robbery served shorter sentences in the era of the rise of prison overcrowding, largely due to others serving minor mandatory drug offenses. Big time "king-pin" traffickers were only

⁵⁷ Later that year the Massachusetts Associate Commissioner of Health, Gerard Boyle, who was responsible for state oversight of EMSA, left his post to take a job as a senior executive with the EMSA corporation (Canellos 1992)

involved in 13 percent of drug trafficking cases in 1993; instead, "girlfriends, first-time offenders and those too poor and far down in the pecking order" are the ones doing "hard time" (ibid).

The War on Drugs seemed to be failing. So-called "hard" drugs were more plentiful and cheaper than they had ever been and the high-level drug pushers once so sought after, when they were caught, bargained their way out of serious prison time. The massive influx of poor, low-level drug offenders serving long sentences filled the jails and prisons, and it appeared to be having a ripple-effect throughout the criminal justice system pushing out those with non-mandatory albeit violent crimes. It also feminized the War on Drugs, indicting the mothers, sisters, girlfriends and partners of men involved in the drug trade who were easy prosecutorial targets. Was the prison even the right place for them or their treatment?

The feminization of the War on Drugs added to preexisting notions of character retraining and rehabilitation for poor women addicted to drugs or alcohol. Yet the prison was largely unable to achieve its goals of rehabilitation given its lack of attention to structural violence and its inability to address the pathological environments to which women inevitably returned after prison.

Much like how primary care clinics grapple with the upstream social determinants of health today, prisons were presented with acute-on-chronically sick women and these problems were deeply entrenched, intergenerational and embodied in women's poor health and everyday habits. Each incarcerated woman who used heroin, for example, had a unique presentation that was a complex interplay of historical, cultural, sociopolitical, economic forces, with unique family and community influences as well as her own individual personality traits. It was difficult, if not impossible, to address all these forces and treatment administrators tended to focus on personality traits and individual decision-making. At times, it was not even clear whose

responsibility it was for inciting behavior change among women deemed deviant and criminal. Was it the responsibility of the individual, the family, the schools, the prisons? Was it even the responsibility of the state or did the state only bear that responsibility inasmuch as to the safety and well-being of the rest of the community? Such questions would arise over time and the public's faith in social institutions of the state would ebb and flow. Yet the prison remained a central, increasingly dominant actor in the treatment of drug addiction, even though it did not demonstrate any particular effectiveness.

Chapter 4: “Programming” Addiction Away

Building on the historical work of the previous chapter, this chapter addresses contemporary drug treatment programs for women in the local prisons and jails. Prison-based drug treatment programs represent the convergence of therapy and a direct form of governance, demonstrating efforts at managing and reforming citizens deemed to be troubled, deviant or otherwise immoral/bad. Such treatment has a gendered component, in which women’s bodies are sites for the inscription of power and class gradients, cultural ideologies and norms as well as being a space of self-regulation/self-management.

Here I look at drug treatment programming in the state women’s prison at Framingham and the local county jail, Suffolk House of Corrections. I argue here that what the prison does is largely a reflection of moral standards and orientations that exist in the larger community and that the prison cannot be analyzed in isolation from the communities that uphold it. But what epistemological orientations do prison-based treatment programs take and how is treatment fashioned for these women? Looking at the experiences of women who participate in treatment across these spaces, I examine how the process affects women as well as the meanings they impart to both incarceration and participating in prison-based treatment.

Scholars of the War on Drugs and sociologists of drug and alcohol use have posited that drug treatment is a form of social control (Campbell and Ettore 2011) and that the “hyper-incarceration” (Wacquant 2010) of poor people with drug laws is a means of controlling the “dangerous” underclasses (Gordon 1994; Covington 2012). Regulations around the use, possession and sale of drugs have been markers of deviance and a means of intervening on the bodies of people marked as deviant, unable to exert control or self-responsibility. It is also a way to blame drug users for a variety of social ills; as historian David Musto claims, a myopic focus

on drugs allows “us to ascribe all the profound social problems of the inner city to one thing... that lets the rest of us off the hook, free to ignore the deeper problems of unemployment and lack of education” (Skolnick 1997:1921). This “War on Drug Users” forces poor people in difficult socioeconomic contexts, increasingly women, to take the blame for social disorder as a result of racialized, geographic, and class-based policing and surveillance. It also has been a means to intervene on the bodies of reproducing women under exaggerated moral panics, like the crack cocaine epidemic, with immeasurable harmful consequences for women and their families (Ettorre 2007; Roberts 1992; Roberts 1991; Radcliffe 2011; Boyd 1997; Humphries 1999).

As I noted in previous chapters, only some women go to prison for drug use (and drug treatment). Which drugs are deemed illicit and subsequently policed is a matter of historical contention (Courtwright 2002; Singer 2008). So which women end up in prison and which women end up in treatment in the community (or in no treatment at all, if their drug use is hidden or tolerated) is also a function of substances, their effects, and the expectations and reasons for drug use. Not all psychoactive substances face such heavy policing and subsequent criminalization— tobacco, coffee, alcohol, sleeping pills, and even amphetamines/stimulants, the so-called ‘licit’ drugs are kept distinctly contained from the realm of “hard” drugs (heroin, cocaine and even marijuana, lumped into association as a ‘narcotic’ by drug enforcement officials). Prescription psychoactive medications such as benzodiazepines and opioid medications increasingly bridge this licit-illicit distinction.

While acknowledging the governmentality of the prison drug treatment project, here I want to foreground the relationships that women have to each other, with themselves and with the institution of the prison itself. How do women experience the prison and how does going through drug treatment alter their potentialities and concretely impact their futures, if at all? Is there a

space within carceral structural violence for spirituality, emotional growth or critical self-reflection?

As I argued in the previous chapter, the prison provides drug treatment as part of an overall larger commitment to rehabilitation and decreasing recidivism. The prison sees itself as only one node in a larger drug treatment system. When the safety nets bottom out for women who struggle with addiction, they often end up in prison. Theories that argue for drug treatment intervention in prison are based on the premise that the prison can be “rock bottom” for many people, and that “hitting rock bottom” is necessary for long-lasting attitude and behavior change (Cunningham et al. 1994). According to this logic, women are at their highest motivation to change and are most amenable to making such changes in their attitudes, their practices and their bad habits.

Many argue that prisons are a natural place for drug treatment; drug treatment researchers Frank Tims and Carl Leukeld note that “for many drug abusers, incarceration may be the only contact with treatment providers” (1992:1). Treatment in prison is called “cost-effective” as well: “The most expensive drug treatment programs cost about \$10,430 per year for each offender, compared to \$20,142 per year for incarceration (DOJ 2000: 60). Yet the prison doesn’t want to be indicted for its failures to rehabilitate drug-using women. One prison administrator somewhat defensively told me to look at the “programming” that women get when they return to the community to see if women will succeed or not. For prisons, the most important —the only measure, in many cases—of success is recidivism, or the return to prison or jail of women who were previously there. Yet how do women measure their successes? What are the ways in which anthropologists of drug use and addiction can re-frame the indicators of well-being after incarceration and “treatment”?

“Likelihood of Serious Harm”: Addiction Treatment and the Problem of Volition

Kim: So you got sectioned?

Kathy: Yup, my mom sectioned me. And I came out in February and I was robbing banks by March.

Kim: So that program didn’t stick.

Kathy: No, now you’re going to see me get high. I came out angry.

Kim: Watch me?

Kathy: I wasn’t ready to stop.

In most states in this country, women who are deemed pathological alcoholics or drug addicts can be “civilly” committed to drug treatment or prison against their will.⁵⁸ In Massachusetts, the state women’s prison, MCI-Framingham, has traditionally received women who were civilly committed to treatment. The Massachusetts law that made sending drug addicts or alcoholics to prison legal (known colloquially as “Section 35”) was passed in 1973.⁵⁹ According to General Laws Chapter 123-Section 35, “Any police officer, physician, spouse, blood relative, guardian or court official may petition in writing any district court or any division of the juvenile court department for an order of commitment of a person whom he has reason to believe is an alcoholic or substance abuser” (Massachusetts Legislature 2013). The court responds to the petition and issues either a summons for the person to appear or a warrant of apprehension.

⁵⁸ Although there has been a long history of civil commitments, in the last century, California initiated a new movement and attention to this law. As historian Nancy Campbell writes, “The U.S. Supreme Court interpreted addiction as a condition akin to illness in *Robinson v. California* (1962), opining that “even one day in prison would be a cruel and unusual punishment for the ‘crime’ of having a common cold.” Deeming it “unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease (*Robinson v. California*, 666-67), the Court held that the state of California could not criminalize a condition, status, or “affliction.”... Indeed, the Court argued that “prosecution for addiction, with its resulting stigma and irreparable damage to the good name of the accused, cannot be justified as a means of protecting society, where civil commitment would do as well” (*Robinson v. California*, 677) (Campbell 2007:135).

⁵⁹ Historically, drunk men were sent to the State Workhouse at Bridgewater as early as 1866. According to the Massachusetts State Archivist Stephanie Dyson, women had also been sent to the Bridgewater almshouse (1854) and the workhouse; in 1922, the women were sent to a special department at MCI-Framingham, the women’s facility. The women would continue going to Framingham for the next eight decades for civil commitments; for the men, a new facility opened called the Massachusetts Alcohol and Substance Abuse Center (MASAC) for both criminally and civilly committed men in 1992.

The court requests an examination by a physician or a psychologist. Based on this “competent medical testimony,” if it is found that “said person is an alcoholic or substance abuser and there is a likelihood of serious harm as a result of his alcoholism or substance abuse, it may order such person to be committed for a period not to exceed thirty days. This treatment order was expanded in August 2012 to consist of “a period not to exceed 90 days, followed by the availability of case management services provided by the department of public health for up to 1 year.”

Civil commitment laws are critical for thinking about the enmeshment of prison and addiction because they demonstrate how the prison has historically become a space of “treatment” but also a space of detention and theoretically, the prevention of imminent harm. The history of (involuntary) civil commitments belongs primarily to the realm of mental illness and is governed by two main legal principles: first, *parens patriae*, that “assigns to the government a responsibility to intervene on behalf of citizens who cannot act in their own best interest,” and second, the doctrine of police power that says the state has “the duty to consider the welfare of all people living within its boundaries” (Testa and West 2010:31). Drug addiction is largely considered to be a (chronically) dangerous condition that alters both the thought process and the thought content of the individual.

The procedure of involuntary commitment is used as an intervention in a wide variety of disorders: most commonly, for mental illness, but also for drug use, eating disorders, and even sex offenses. As Paul Brodwin notes, involuntary commitment is the “stick” with which to force patients with mental illness to comply with case workers’ mandates to take their medication and to behave compliantly in the community: “Commitment is both a legal and medical process, and it both ensures and denies rights. That is, it manifestly treats people against their will, but

according to expert views of mental illness, such treatment will restore their insight, their full moral personhood, and hence their very ability to exercise rights” (2013:160).

Civil commitment programs with varying levels of coercion (to outpatient treatment, inpatient treatment, to inpatient prison treatment) have been extensively studied in the treatment of drug addiction (Belenko 1999; Leukefeld and Frank Tims 1988; Prendergast et al. 2002). The proponents of civil commitment argue that the potential harms of continued drug use outweigh the risks: in the worst-case scenario, overdose, severe illness or death. The detractors argue that until an individual is ready that the treatment won’t take. In many cases (as Kathy’s case epitomizes), people who are the object of the civil commitment feel as if they need to retaliate against family members who committed them upon release.

Many of the women I met in prison had been “sectioned” before, either by their family or by themselves in front of a judge. The Bureau of Substance Abuse Services (BSAS) estimates that 20% of the civil commitments are due to families or individuals desperate for treatment, reflecting the overall lack of availability of inpatient or residential treatment beds. Many family members do not realize that sectioning their loved ones could result in incarceration.

The mass.gov website explains that “Section 35” is not “the only option” (mass.gov 2014). As they explain to concerned friends or family members “This is called setting your bottom line. Examples of bottom lines can be: Not lending the individual any more money. Not allowing her/him to drink in your home” (ibid). The court can order commitment only if: “1. There is a medical diagnosis of alcoholism or substance abuse, AND 2. A likelihood of serious harm to the subject or others as a result of the substance abuse exists.” Examples of “likely serious harm” include “the person can’t think clearly enough to care for or protect themselves in the

community” or that “the person’s behavior makes others fear violence” or “the person may badly injure themselves.”⁶⁰

In 2006, the Department of Public Health's BSAS division established a new addiction treatment center for women, the Women’s Addiction Treatment Center (WATC) in New Bedford. WATC is administered by the High Point Treatment Center, a non-profit drug treatment organization operating numerous drug treatment programs throughout the state. WATC is composed of three units: the detoxification unit, the clinical stabilization services (Tranquility Inn), and then the Transitional Support Services (New Chapter). WATC is “staff-secured, but not locked.”

In Massachusetts, the number of women civilly committed for drug addiction has only increased, perhaps reflecting increased awareness about the legislation as well as the high prevalence of opiate drug use. In 2006, 346 women were committed to WATC; in 2012, there were 1,557. WATC now has 90 beds, but many women still go to prison if WATC is full. In addition, the expanded period of allowing women to remain up to 90 days for treatment, a well-intentioned measure to acknowledge that thirty days seemed inadequate for sufficient treatment, means that there are even fewer beds available. The Massachusetts Women's Justice Network, an advocacy group for criminal-justice involved women, posits that there is an important racial distinction between the women sent to WATC for treatment and the women sent to MCI-Framingham for treatment: according to them, the women sent to WATC are largely white and educated; African-American and Hispanic women comprise 31% of the civil commitments sent

⁶⁰ The website tries to educate family members about what a civil commitment can or cannot do: “Recovery is a process and detoxification is a start. For some individuals, a civil commitment to treatment begins their recovery. Others do not see it as a need to stop using alcohol or other drugs.” The possibility of being sectioned again always exists depending on the “current likelihood of serious harm,” although “it does not address many individuals whose chronic use of alcohol or other drugs may have dire long term consequences.”

to MCI-Framingham versus only 8% of the civil commitments at WATC (Massachusetts Women's Justice Network 2013).

The differences in experience between WATC and MCI-Framingham are vast. Being sectioned to WATC meant that a woman could access detoxification medications such as methadone, clonidine, or chlordiazepoxide (librium) for coming off opiates and alcohol, a regimen that they could access in community detoxes or hospital programs. Being sectioned to MCI-Framingham meant getting at most clonidine or librium. The women who get sectioned to MCI-Framingham live in a section of the prison called the "Mods," short for the "Modular Units." By law, the prison is forced to house the civil commitments in separate housing from pre-trial detainees or the sentenced women. This means that the sectioned women cannot participate in any of the programming on drug treatment, domestic violence or education. The "mods" is one giant dormitory-style, gymnasium-esque room. Women are required to keep their things in a trunk at the foot of the bunk beds. One woman, Jess, who was committed, explained the set-up: "I'm pretty sure it was 80-something beds in there... It's horrible. If one person isn't sleeping, no one is sleeping."

MCI-Framingham has difficulty handling the civil commitments as well. The staff report that they spend inordinate amounts of time trying to find drug treatment programs when WATC is full, and they deliver the women to the community drug treatment programs only to hear that the woman has run from the program almost immediately (so-called "runners"). "You can almost immediately tell who are going to be the runners," one prison staff member said. "They want to get into any program possible, and then they run away immediately. They're wasting taxpayer money. And DOC pays \$10,000 per bed, regardless of if they go or not. The treatment facility takes it."

Women are of mixed opinions about sectioning and being sectioned. Some saw entering state-mandated drug treatment as a last ditch effort to avoid going to prison or jail and they would draw on the “self-sectioning” strategy, blurting out to the judge that she was an addict.⁶¹ Macy said that she sectioned herself after leaving detox because she knew that she would otherwise pick up heroin, having to detox off the methadone used to detox her off the heroin.

The state civil commitment law for addiction presumes that inpatient treatment is necessary, effective or at least overall more beneficial than it is harmful. This is not always the case. Many of the women in my study reported that when they were released from WATC, they were back to using within the week, often within the day or hour. The enforced abstinence of being in jail or being civilly committed can beget vengeful and righteously renewed drug use; it also places them at high risk of overdose since they lose physical tolerance. Mae tells me that she got sectioned twice, once by her mother who was angry at her for starting to shoot heroin instead of snorting it, and then again by her mother eleven days after she was released from WATC. Mae tells me that when she went back, she learned that two of the women who had been in the earlier cohort with her were dead: “The people that work there say that two or three of every group of girls dies as soon as they hit the streets.”

Mae stayed 25 days at WATC the first time and 22 days the second time. The treatment consisted of group programming, education, and recovery-based skills, but they were useless against her drive to use: “I had just found shooting up a little before that and my time was not up with that. I was pissed, absolutely pissed. It was literally a newfound love... I got out, and I

⁶¹ Others suspected they were going to be sectioned by their mothers. Kathy, a 30-year-old woman from Charlestown, had an unexpectedly bad outcome. Kathy’s mother caught her about to use heroin in her bedroom. She yelled that she was going to section her; Kathy hurriedly grabbed some clothes and told her mother she was leaving the house. She assumed (partly correctly) that a judge at the courthouse had to declare her “sectioned”; little did she know that her mother had already called the cops, telling them that her daughter had assaulted her and she needed to go to drug treatment, that her daughter was a heroin addict. The police arrived at the house and arrested Kathy. When Kathy’s mother later tried to drop the charges, the District Attorney instead chose to prosecute anyways. Kathy was convicted of assault and battery and is now serving two years.

caught three more [criminal] cases in that week, because I'm like I'm going to show you [her mom]." The second time that her mother sectioned her, Mae thought it was retaliatory for her bad behavior. After she left WATC the second time, she vowed "to get wrecked... to come home and I'm going to put my face in my mashed potatoes because I can't get up [too high] and I'm going to show you."⁶²

Mae's story, and the vastly increasing number of civil commitments for women who use drugs in Massachusetts, actually reflects the dearth of community detoxification programs, transitional services and longer-term residential drug treatment programs for women who use drugs. Being sent to prison is no real solution to the problem of drug addiction for women who have committed no crimes per se, enmeshing women in a surveillance and police state that can harm them more than help them instead of diverting them into community treatment. What it does provide is simple detainment, which some women actually claim they need to ever stop using drugs. The idea of needing to be locked up to protect one from oneself elucidates the problem of volition and the nature of addiction, a core and thorny question that is central to thinking about drug treatment and the incarceration of drug addicts more generally.

Detoxification

Opiate drug treatment inevitably starts with detoxification. Women who use heroin or prescription opioids describe the process of going into withdrawal from these drugs as extremely painful. Being physically weaned from the drug, washing the body and the brain's *mu* opioid receptors clean, after months or years of accommodation to the presence of the drug, is not

⁶² Her mother is also a drug addict and uses often with her daughter. Mae thought she was going to court for a clerk's hearing, and her mother had given her a solidarity present for her courthouse anxiety: "Five Xanibars [street name for Xanax] and then she gave me 3 perc-30s and I shot two before I left the house." The court employees with the Section 35 commitment order suddenly ambushed her and she was too high to resist.

pleasant. There are embodied manifestations and mental consequences that wax and wane but remain constant in their unpleasantness. Brittany, a 23-year-old white heroin addict, tells me she knows exactly when she is getting “sick,” as street addicts refer to the process of withdrawal. It is like clockwork, yet unpleasant time and again. The stages of dopesickness begin with “an itchy thing in my throat, coughing, thinking I’m going to throw up. Then it’s on to the goosebumps, then it’s hot and cold, then it’s my legs kicking and the sugar craving.” She tells me these stages as she talks on the phone trying to meet up with her boyfriend, hoping he has managed to get some heroin.

Going through withdrawal is so unpleasant that many people will do anything they can to avoid experiencing it. For many, the fear of “getting sick” is a fierce motivator to find drugs and money for drugs. Many go on long “runs” out on the streets, using, resting, hustling, repeating the cycle several times a day. Many women told me that the only way they were able to stop was when they were picked up by the police and were detoxed against their will.

In a hospital environment, physicians can administer a variety of medications to ease the physical symptoms of opiate detoxification—the disruptive violence of a body acting out—to make the immediate process less uncomfortable over an inpatient period of 3 to 14 days (Berman et al. 2008; Ling et al. 2005). The standard of care in most hospitals is providing an opiate substitute and subsequent taper to nothing. Women have told me that it is entirely possible to detox in a seamless fashion with limited physical discomfort. The heart might still race, the sleeplessness and anxiety still linger, but the body feels less wretched.

The vast majority of criminal justice institutions will not administer opioid detoxes to anyone. At best, a person might receive clonidine, an anti-hypertensive medication found to be useful as an adjunct for easing the withdrawal symptoms (Gold et al. 1980). Heroin addicts, who

are masters of ingesting a variety of pharmacological substances to achieve certain desired effects, have shared certain common tips to make a prison detox less painful. Mae tells how they all talk in the "paddy wagon" to the "girls coming in for the first time." They say, "Don't even say you're addicted to heroin because you're not going to get anything, tell them you're a severe alcoholic and you'll get Librium." The staff have to give medication to women who are alcoholics since detoxing off alcohol can be potentially deadly (seizures known as delirium tremens), and therefore it is necessary to give women a low-dose benzodiazepine like librium to taper them off. This can help bring sleep and a certain amount of ease to a situation fraught with angst, discomfort and fear. The main exception to this detox protocol are women who are pregnant and addicted to opiates; in many cases, they can be maintained on methadone maintenance therapy for the entirety of their pregnancies.

At MCI-Framingham, the women who are detoxing are housed in an individual part of the medical building called the Health Services Unit (HSU for short). They might receive Librium or clonidine there. Most women, contrary to what you might expect, want to spend as little time as possible in the HSU. The conditions there are fraught: there might be three other women in each cell, everyone going through withdrawal. The suffering of one's body is immense, but perhaps not as intense as the combined suffering of the other dopesick women, who might have vomit-stained shirts or even worse, diarrhea. Allowed out of the cell for only one hour a day to clean up, the women would much rather be sent to the general unit where they can at least "walk it off." Many community addiction specialists believe that such "cold-turkey" detoxes are punitive in and of themselves, especially since it violates the standard of care provided in the community.

Two summers ago, I spent a summer in Cook County Jail in Chicago, one of the largest jails in the country and dubbed one of the nation's "mega-jails." The jail had a standing inmate population of approximately 10,000 people, give or take a couple thousand, and over 100,000 people cycled in and out of that jail a year. That jail took a different approach to opiate addiction, at least taking into consideration the painfulness of detox. For inmates who came into the jail reporting that they had been on methadone maintenance for opiate addiction at community-based clinics, the jail would verify it with the caseworker at the clinic and would then "dose" the inmate the next day. Inmates would then be tapered off methadone (reported to have a worse detox than even heroin—it "gets in your bones and you can feel pain in your hair") over the course of approximately 25 days. In Massachusetts, even if you are on medical treatment for heroin addiction (methadone or suboxone), you do not get this semi-humane approach; rather, you get the puritanical, painful withdrawal method. This is not unique to Massachusetts: a 2009 study showed in a survey of 51 state prison systems, only 55% of the system offered methadone to inmates, mostly for pregnant addicts (Nunn et al. 2009:83). The most commonly cited reason for not offering an opiate replacement therapy for detoxification was that these institutions "prefer drug-free detoxification over providing methadone or buprenorphine." It is also just cheaper for the prisons.

All the women who come through HSU with a known opiate problem are sent to one cottage where a program called "First Step" is run. It is a mandatory twenty-day program run by Spectrum Health Systems, the external vendor that runs all the drug treatment programs at Framingham. It is a "post-detoxification" program "designed to provide initial substance abuse education and comprehensive discharge planning." All the women live together--in either Brewster 1 or Brewster 2--and Mae declared it "fucking disgusting." The program is residential

and largely group-based, with basic educational classes on overdose prevention, cravings and urges, HIV and infectious diseases, and general health. Yet Mae affirms that the First Step program is unpleasant because women are still detoxing, and they are subsequently unhappy and ornery due to ongoing discomfort: "There's pretty much 9 girls in every room and there's 10 rooms. So there's 90 girls in one unit, all detoxing, coming right off the street." All the physical sickness makes the programming at First Step difficult. Tina affirms that Brewster was out of control: "The girls were smoking crack, taking the toaster to light the straight shooter [used to smoke crack], doing stupid stuff like that, until they finally got caught, got hauled off to the hole. It's ridiculous what people do to get high in there."

After First Step, the drug treatment staff encourages women to move on to the next program, the Women's Recovery Academy (the WRA program). The WRA, also known as the Corrections Recovery Academy (CRA) in the past and at the male prisons throughout the state, is a "modified therapeutic community" (TC) drug treatment program that is "based upon what works in offender rehabilitation."⁶³ The women live together in one of the cottages in a low bunker-like house of cells called Townline (although the cottage is not exclusively WRA clients). According to Spectrum, the program's "therapeutic community functions as a distinctive community within the host institution, providing a highly structured and supportive learning environment in which to address criminal addictive behaviors" with particular "emphasis... placed on mutual respect, accountability and responsibility."

⁶³ Many prison-based drug treatment programs are modeled off therapeutic communities because they offer "intensive, highly structured prosocial environment for the treatment of substance use and addiction" using a punishment and reward system "directed toward developing self-control and responsibility" (Welsh 2007:1482). A research study of a Delaware prison TC described this program as "designed to provide a total treatment environment in which a drug user's transformations in behavior, attitudes, emotions, and values are introduced and inculcated" (Martin et al. 1999:297). Much research has been conducted on therapeutic community prison drug treatment programs because they have been widely adopted across the country (Martin et al. 1999; Wexler et al. 1999; Butzin, Martin, and Inciardi 2002; Inciardi, Martin, and Butzin 2004).

There are certain requirements for participating in the WRA program. It is partly a process of self-selection and partly a matter of meeting the requirements of the prison. In order to participate, a woman needs to have a certain length in her sentence as well meet certain criteria in her profile and “classification” level; she can get up to ten days of good time a month for participating plus an additional ten for completing the entire thing. The program only admits inmates who have a sentence longer than nine months--the full program is six months minimum. One of the treatment administrators at Spectrum noted that the WRA also competes for the affections of the women with other kinds of programming including working around the compound as well as educational and vocational classes (the culinary arts program or the hairstyling course). These other forms of programming may appear more desirable and important to the women. Then there are some who are most concerned with the housing assignment: they don't want to live in the drug treatment house or they have a girlfriend in another cottage.

Many women are uninterested in the drug treatment program offered. As one African-American woman named Linda told me, "I wanted to do my time and get up out of there." She had been in and out of prison for the past 30 years and MCI-Framingham was an institution she knew all too well. Over her thirty years going in and out of the prison, she witnessed the consistently short-lived spans of case workers, counselors and treatment staff—young blonde women trained as social workers or teachers who had no conception of what life on the streets entailed—and they were telling you to "surf the urge"? She did not find the treatment staff particularly compelling nor did she trust anyone in the institution with her intimate "issues." She questioned the adequacy of their training, their ability to relate to her life history and problems, as well as their overall commitment to treatment in general. Why did they care about her well-being if she kept coming back anyways?

Risk Level and Needs of the Offender

The WRA program is not necessarily offered to all inmates in the prison. Excluding those with short sentences or those with civil commitments, women have to demonstrate that they have a “substance abuse problem.” The way in which the prison assesses this is through a survey instrument called the Criminal Offender Management and Profiling for Alternative Sanctions (COMPAS). The COMPAS instrument was developed by Northpointe Institute for Public Management around three main principles called the “risk-needs-responsivity model.”⁶⁴ In this view, “risk” tries to assess what level of “risk” the individual poses to the community upon his or her release from prison or jail. “Needs” is meant to take into account the individual’s own problems, or in other words, “targeting for intervention the personal, family and social deficits (i.e. criminogenic needs) of an offender which research has shown to increase the likelihood of recidivism.” Finally, a focus on “responsivity” is the individualization of a unique program, that is “providing cognitive behavioral treatment that is tailored to the offender’s unique profile” (Lansing 2012:1).⁶⁵

The WRA is a “modified therapeutic community” based on the notion that drug addicts need to learn how to function successfully within family and community hierarchies; in the original iteration, residents of TCs would take on more active roles and responsibilities in the house, including “acting doctor” and pointing out others’ problems and “self-deceptions”

⁶⁴ Risk assessments have not always taken gendered experience into account. Mary Ellen Mastrorilli, a former head of probation and now a Professor at Boston University, told me who they used to use one risk-assessment tool that had a question “Leisure Activity: How Many Kids Do You Have?” Outraged, she translated what the question implied: “Because for men, having kids is a leisure activity!”

⁶⁵ The WRA program only offers treatment to women who are deemed by their COMPAS score as at medium- or high-need for substance abuse treatment. One of the directors of the program cited evidence showing that giving treatment to women at a low level of need for substance use treatment could actually make them worse. Women must demonstrate sufficient “needs” or “risks” in their profiles that try to provide treatment for individual deficiencies while balancing concerns for public safety.

(Yablonsky 1989:97). In original TCs, individuals participated in three phases over one to two-and-a-half years. Spectrum describes the phase system of the WRA: “Program objectives seek to address known contributors of substance abuse and criminal behavior such as dysfunctional interpersonal relations, poor impulse control, and inappropriate responses to authority. Throughout sequential treatment phases, offenders’ behaviors, attitudes, values and emotions are continually monitored, corrected and reinforced.”

The orientation of TCs to drug addiction is conducive to prison treatment; they believe that “the problem is the person; not the drug” and “individuals are distinguished along dimensions of psychological dysfunction and social deficits” (De Leon 2000:4). Dr. Judianne Densen-Gerber, a founder of the Odyssey House TCs in New York City in the 1970s, felt that their program appealed especially to the police: “It is based on law and order. We believe that strict enforcement of the law increases the possibility of getting people well. It is the first step to treatment. Only with law enforcement and medicine working together can addiction be conquered” (1973:41).

The original proponents of the TC model felt like their program worked particularly well with seemingly recalcitrant groups of people, including “women convicts” (Yablonsky 1989:42).⁶⁶ They proposed using the term “habitation” instead of “rehabilitation” since

rehabilitation implies that treatment restores something that was lost, whereas habilitation emphasizes the view that recovery is a learning process during which a person is socialized quite possibly for the first time, to lead a life of right living...they will begin to live right, by telling the truth, adopting a prosocial moral code of what is right and what is wrong, learning a work ethic, living in the here and now (Hiller et al. 2006:742).

⁶⁶ Yablonsky wrote that therapeutic communities were useful in treating “those who have repeatedly failed in other therapeutic communities and treatment centers, including former counselors who are frequently the most cynical and disruptive; Hispanics and Native Americans; men who have done five years or longer of hard prison time; women convicts (a hard group to impact, virtually voiceless in our society); severely institutionalized adolescents—boys and girls; women with children; women with histories of prostitution; and men with histories of prostitution and homosexual rape” (1989: 42).

Patients would learn how to lead a “life of right living” by learning how to live and play well with others according to dominant social norms and expectations.

Of course, the inmates in the prison can never become staff as in the original TC model. The strict delineation prohibits such a blurring of roles. It would impossibly upturn the prison’s rigid and brittle hierarchy, exposing the farce of it all, that guards and officers and program managers are also fallible, at times weak, selfish, impulsive in short, human. But the inmate is required to live in Townline and take on the drug treatment program “on a 24/7 basis” and participate “in all aspects of the program on and off the Unit.” She is required to do chores or cleaning, duties useful to the whole “house.”⁶⁷

Many observers have criticized the use of the confrontational core techniques utilized in a therapeutic community programs when working with women with histories of trauma or abuse; White and Miller note that confrontational techniques such as the “hot seat” used at Hazelden in Minnesota in the women’s unit were “stopped when it became viewed as too harsh and disrespectful” (2007:10). In traditional TCs, the other peers and staff confront or yell at one individual for her deficits, bad traits, behaviors and attitudes.⁶⁸ This was known as “giving someone a haircut.” They also utilize psychological “self-reinforcing” concepts they have dubbed “pull-ups” and “push ups.” Pull-ups are when peers are “expected to speak to (remind) remembers of lapses in expected behaviors or attitudes”; the “push up,” on the other hand, is

⁶⁷ It is also difficult for Townline to actually be a “modified therapeutic community” given that the cottage is not entirely populated by just the WRA “clients.” At any given time, of about a total space for 60 women, about two-thirds of women in Townline are in the WRA program and one-third are just overflow. They attempt to house the graduates of the program in Townline in order to keep them around and a part of the therapeutic environment.

⁶⁸ According to White and Miller, this stems from two traditions. Lawrence Kolb, an addiction specialist from the 1920s, proposed that individual psychopathy and social adjustment would require “treatment as ... a period of quarantine with a structured program of institutional care that could enhance personal maturation and pro-social values.” It also came from Dr. Harry Tiebout’s psychoanalytic work with alcoholics in the 1940s and the 1950s. As White notes, “The alcoholic in his [Tiebout’s] view was incapable of accurate self-perception due to an elaborate system of defense mechanisms (e.g., denial, projection of blame) that simultaneously justified drinking and buttressed self-esteem” (2007:15).

meant to provide "positive feedback... to encourage the flagging resident or to affirm any sign of progress in a peer" (De Leon 2000: 169).

Brittany, chunky with prison baby fat with piercing dark eyes and chestnut curls, is in the WRA program. This was her second time in the prison for the same case: possession and operating under the influence (OUI), a complicated situation that took at least twenty minutes for her to explain. She had pleaded upon her arrest that she was "a raging drug addict" that was why she had so many pills on her (to "break through the methadone" she claimed). The numerous perc30s that she had tucked in her underwear were for her own use. She was sent to WATC instead of prison and while she was out on pre-trial probation, she kept "screwing up, getting high." So the judge sent her to MCI-Framingham where she served three months. She left on two years of probation and lasted six months until she was sent back to prison "for a year."

The six months that she was out on probation in the community were stressful and fraught, as she tried to get high and "tuck urines" (in this case, someone else's urine, often a child's, in a nip bottle in her vagina) so she could "piss clean." She would trade pills for urine. Most of the time, "they didn't even catch me," she explains, and it was mostly "my mom calling my probation officer." At a "surrender" hearing for a violation of probation, she told them she wanted to go to a program. "No," the judge said, "You're going to do a year at MCI. Do the program there."

When I first meet her in the Old Administrative building (known for short as Old Ad), she tells me that she has never completed a program before and this is the longest time that she has ever been clean in the past six years, since she was seventeen. She is about to take her Phase Test from Phase 2 to Phase 3. According to the WRA program, Phase 1 is the assessment and orientation phase. Participants at this phase have to memorize the "Absolute Rules" and the

“Basic Guidelines” of the program as well as develop an individualized treatment plan with a counselor. They have to master the “Philosophy” that is recited every day in Morning Meeting; they have to understand and be able to use the concepts of “Redirects, Good Jobs, addiction, recovery, criminal addictive thinking, core skills, and principles of recovery, the inner self and the habit self.” Then they must successfully pass the Phase Exam that they can take whenever they feel ready.

Phase 2 is the real heart of the program, the “active” phase. It is the most inward-turning, with clients closely examining their own lives, behaviors and the impact that their decisions have had on other people. To graduate, an inmate must “demonstrate learned pro-social thinking and behaviors; demonstrate the ability to handle potential real-life situations constructively; demonstrate competence in identifying and handling personal high-risk situations; demonstrate recognition of and countering of thinking errors and negative behavior patterns” among many other stipulations.

Phase 3 is the “Relapse Prevention & Exit Planning” Phase where individuals consider how they will maintain and utilize the skills and supports they have acquired and cultivated in the earlier phases of the program. They are expected to serve as mentors to new women in Phase 1 and plan for their release. Graduating the entire program (and getting a final ten days of good time) requires an interview with the Director of Treatment of the prison, the head of the WRA program, and the Regional Director “to assess your ability to integrate the concepts, principles and skills of the Therapeutic Community into your daily life.” The twelve exit questions include things like “define what humility means and how you express that behavior consistently” and “name one time you have used a skill you learned in the program to cope with a personal challenge.”

One day, I was able to sit in on the WRA program. One sunny morning, I went with one of the correctional program officers (CPOs) to Townline for the morning session. Each of the Phases meet at different times throughout the day. I was interested in seeing how the programming might work for a woman like Brittany. Here is an excerpt from my field note from the previous summer:

The group is held in the “cottages” on the unit in the main living room are of the cottage. That area is set up with plastic tables with four chairs attached and the women are clustered near a fake fireplace where the facilitator is teaching. The CPO doesn’t know who the CO [correctional officer] is at Townline, so we have to rap on the window in order to gain entrance. When I get there, my escort doesn’t do a very good job explaining who I am and they are in the middle of a Family Feud style game (“Team Winning” versus “Team Divas”) on health and wellness. I don’t want to interrupt, so I just sit at a table at the back with two women. As they are playing their game, with questions ranging from gingivitis, plaque, and other kinds of health-related issues, I try to take notes about the unit and the program. The facilitator stands near the front near the fireplace asking the two teams of women questions. Near her is a white board that reads: “Goal: Share an experience that helped you stay clean. Word: Transcend. TC Slogan: Stop and think. Reading: Life is 10% what happens and 90% how we read it. We cannot change the inevitable!!!”

Two of the women at my table are white. They joke, “Oh she’s on our team, she’s a med student!” implying that they will have some kind of advantage. They are much older and look to be in their mid-40s or even 50s. It’s hard for me to be completely uninvolved from their game, but in the meantime, I take notes. There are 12 women not counting the facilitator, a young white woman. 10 of them are white, two of them are black. I wonder if this represents the over-whiteness of prison programming; but Massachusetts just has a larger percentage of white people in prison than other states. One of the black women looks transgender to me and has facial hair and a shaved head.

The wall of the living room where the group is being held is decorated with outline drawings of the human form and hands. They appear to be completed by women in the program. Under the prompt that reads, “five years from now” the women have written in slogans: Don’t get complacent! Stay strong. Appreciate every moment. Stay focused. Remember where you came from. Sober, confident and independent. Continue with sobriety. Strive to be where you were 10 years ago. Learn to budget and appreciate life. I [heart] me!

The game ends, with Team Divas beating Team Winning. During the break, one of the women comes up to me, shakes my hand introducing herself and talks to me about being in another Harvard-based sociology study of prisons. Another woman chides me about looking not

a day over 21. Awkwardly, I tried to deflect attention from myself. The groups were switching, from Phase 1 to Phase 2. Brittany must hear that I am around, so she comes to say hello to me during the break. We hug and she tells me that she is getting ready for release but is full of anxiety. She has been in touch with several of her ex-boyfriend-dealers who are vying for her attention and she is debating which one of them she should return to upon her release from prison.

We have to interrupt our conversation as the second phase's group begins to start. Phase 2 was significantly more inward-turning than Phase 1, whose activity was a health-related game based on knowledge. Today the session is on CRT (community recovery training). The theme today is "life is not fair." The women turn in their homework to the second facilitator, a young white woman. It's incredibly distracting to do the group in the main area because all around the other women who aren't in a program are doing chores, making a lot of noise. Two women almost get into a fight near the CO station where the guard peers out at everybody from the centralized control perch.

Finally, things seem to be settling down. One young white woman monopolizes the group conversation. She says, "Life is not fair" is like "Poor me! [another drink]" ... Everyone laughs but the facilitator nods solemnly. The teacher writes up on the board: "Why can thinking this way lead to trouble? Seeing that life is not fair and that one may have been dealt a bad hand can be an excuse for not trying to make things better. The inner self must learn to listen and overcome the fears and grudges of habit self."

Everyone writes down this sentence into their notebooks. I am tapped on the shoulder by another CPO from the Old Ad building and asked to follow him. Quietly, I leave with him and my heart is racing in my chest. What have I done? He tells me the COs were getting edgy, anxious about my presence. They told the director of the drug treatment programming they had some kind of "proof" on tape. It becomes clear after talking with several administrators that I had touched one of the women and they were anxious about the woman who asked about my age and that I had answered "personal questions." They had their eye on her as a manipulator, a known problem-maker.

One of the head administrators of the programming at the prison, the CPO's boss, sits down sympathetically with me to explain. She told me that she didn't go in there herself because it would have caused a big stir and would have given the COs an "ego boost" that she did not want to validate. It was a "possible situation," a power play between treatment and the guards. It is not uncommon, she tells me.

My fieldwork encounter demonstrated the inherent tensions and contradictions of prison-based drug treatment. Importing the community-based, peer led mutual help models from the community does not smoothly cohere when there is a strict hierarchy, rules about everything,

constant surveillance and punishment at every turn for anything deemed bad behavior. The women in the WRA program are told that they are incarcerated drug addicts largely because of their inability to comply with rules, to act in a socially appropriate manner, to settle disagreements without fighting or engaging in self-injurious actions. The WRA program believes that structure and even stricter, harsher surveillance than the rest of the prison population will lead to success. That is why the women in the WRA program are drug-tested more often, at least, that is one reason. They are supposed to be clean; they are ostensibly striving for sobriety by participating in such a rigorous program. The other reason is more obvious: thirty to forty women with significant drug problems living together in one cottage? Certainly one or more of them, individually or in coordination, will be able to get drugs into the prison.

In the next section, I highlight the course of two women who both graduated from the WRA program. Using their life histories and exploring what shape their lives take after prison, I show that drug treatment is not a flat, unimodal experience where women are just passive receivers of information. While the treatment program may have facets of social control, surveillance and punishment, it also provides knowledge that women were never able to access in other venues, new ways to think about the self and take action in the world and a space for critical self-reflection. The drug treatment program can be many things for different women. Much as Megan Sweeney's work on how women engage with books and the "art of reading" in prison, I believe that there are a "myriad [of] ways in which women claim their humanity, practice freedom, and transform themselves while in the grip of 'a death-generating institution'" and that women in prison can and do "achieve critical insight, self-development and even transformation" (2010:3-4).

Tina Stinson's Success

Tina Stinson credits the WRA program as saving her life. She is a 52-year-old that I met in the community addiction clinic; her gray-brown hair, sweatshirts and thin-rimmed glasses make her look more like a grandmother than a former heroin addict. The unadorned facts of her life include: rape by her father from the ages of 9 until 13, pregnant by her father at 13, baby at 14. Originally from a small sleepy town in the Midwest, she started shooting drugs at sixteen after her family blamed her for “trying to break the family up” and her older brother introduced her to heroin. She met a pimp in 1988 who took her traveling around the country for twenty years with a group of other “girls.” She had five children by him, including two sets of twins. One of those sons was killed while leaving a convenience store in New York City in an attempted robbery for a \$10 “gold” chain. Tina was in MCI-Framingham at the time and they did not let her attend the funeral.

Tina has been incarcerated over 20 times, by her recollection, all for non-violent addiction related activities like shoplifting, larceny over (\$250), car theft. Her longest and most recent incarceration was at MCI-Framingham for four years, for a ‘hand to hand’ in a school zone, in which she received a sentence for a year for possession of a gun that was not hers as well as another 3 years and a day. She had no option for parole given the 1993 “Truth in Sentencing Act” that led to lengthier prison sentences for minor offenses (Ditton and Wilson 1999). She was a low-level part of a cocaine and heroin enterprise in a hotel based in Revere, and the big drug dealers signed statements saying she was the head of their operation and “they wanted to give me fifteen years.” Who would believe that “a junkie prostitute” could handle such an operation? The two men, Easy C and Big Chris got two years and three years, respectively, even though they had more hand-to-hands. She was also sentenced under the one year mandatory for being “in a school zone.”

During her last incarceration, Tina was dopesick when she first arrived. She was sent to the HSU and was kept for five to seven days in a locked medical cell with five other girls who were also “kicking it.” During this time, she received clonidine, Imodium and motrin. Next door to her cell in HSU there was a 17-year-old girl who was kicking methadone. She had been “sectioned” by her parents, who did not know that she would be sent to prison instead of drug treatment. Tina says that, because the girl next door would keep screaming for help, the guards disabled the call button in order not to hear it. When the guards finally checked on her, they discovered that she had hung herself.⁶⁹ It is still traumatic for Tina to recall this incident many years later. It is conventionally taught that withdrawing from methadone or heroin is unpleasant but not fatal. But the combination of emotional and physiological distress and suffering of incarceration can obviously take a fatal toll.

Tina signed up to participate in the WRA/CRA. There was a long wait list and she thought that a lot of people did it for the 7.5 days of good time it offers per month.⁷⁰ Tina told me that the class was frequently suspended and interrupted by a near constant state of lockdowns (i.e., if the count of the spoons and forks in the cafeteria was off, if there was a fight in the yard). The COs also listened in on all the programming, since the class was taught in the TV room of the common area.

⁶⁹ The woman who died was named Nicole Davis, 24 years old. She had no criminal history and was incarcerated at MCI-Framingham for a civil commitment to a 30-day drug detoxification program. Her suicide was the sixth in one year in state prisons and a seventh occurred days later at MCI-Walpole. As the Department of Corrections spokeswoman, Susan Martin, was quoted saying, [MCI-Framingham] is a jail, it’s a detox, it’s a state prison, it’s a house of corrections” (Prison Is the Wrong Place for Treatment 2006).

⁷⁰ Interestingly, men got 12 days of good time for completing the same program, most likely reflecting the overcrowding of the male facilities and the need to incentivize and move men more quickly out of facilities. It also reflects a gendered double standard that Nicole Rafter has shown historically exists for incarcerated women versus men.

Tina gave me some literature from the CRA program. These included the 12 steps series from Hazelden; a guide to managing your cocaine addiction; and a guidebook for women's recovery and relapse. "Turn a negative event into a positive one by gaining knowledge and strength from it. Take responsibility for making the necessary changes in your attitude, your lifestyle, and your behavior." Some common triggers for cocaine use include: "Getting paid; feeling stressed; bored, lonely, tired, angry, or depressed; feeling sexually aroused or deprived; holidays, weekends, and other celebrations; thinking or talking about using; being around other people who are using or talking about using." In other words, all of life is a trigger.

Another component of the treatment program was an exercise called "playing the tapes." Tina describes "playing the tapes" this way: "We used to have to write out these things, what we did, what were the consequences, and how to, if it happened again, how to stop it again by playing the tape. You sit down and think about it before you act on it. You sit there and think about what the consequences I just did for selling drugs and getting caught. Instead of getting drugs and getting caught, get a real job, this way I have money, you know."

Tina graduated the WRA program in Framingham and was re-classified to minimum security. She was sent across the street to SMCC (the pre-release facility) where she participated in the same program. One condition of participating in that program at the time was the need to look for work or they would write you up for a D-report (disciplinary report). She found work at Bruegger's Bagels and accumulated over \$7,000 in savings working there for three years.

Tina left the prison to return to the streets when she was released from the pre-release two weeks before her actual 'rap date' because no one had factored in her good time. Her caseworker at the pre-release had lined up a bed for her in a sober house, but there were no beds available two weeks earlier. The prison refused to let her stay until a bed became available. The stress of

being discharged with nowhere to go took a toll on Tina's chances for maintaining sobriety. She made her way back to Boston after being released at the Mattapan Prerelease Center. Fortunately, she was able to reach out to contacts that she had met in prison and knew from her life before in the streets that led her to a three-month inpatient drug treatment program in the community in order to hide from an abusive ex-boyfriend. From that program, she was introduced to the suboxone clinic where she has been a patient ever since, stable for the past four years with no arrests or incarcerations.

Tina has mixed feelings about her time in prison. She feels like she was given no other option—no drug court, for example, that she would have certainly taken—and no options for treatment programs in the community even though “my lawyers fought for a program and I think if I had went into a program and learned some of the stuff that I learned in jail, I think I could have been successful.” It was hard to get treatment in the community and basically entailed getting on a number of waiting lists: “Even when people are out there seeking help, all the beds are full. Get a slap in your face because the government doesn't want to pay for the bed.” Really the fastest way to treatment is to get locked up, and the longest period of treatment she had ever received in her life was while she in prison, more a testament to the state of drug treatment more generally than anything else. It always seemed as if the longer-term residential programs were closing down all the time. Drug researchers note that “it appears that the most commonly used interventions for the drug-abusing offender should be more intense community treatment programs. However, along with that need is the realization that these interventions (like residential treatment) are the most expensive and the most limited community treatments available” (Tims, Leuekfeld and Platt 2001:45).

Tina values the treatment program for its educational component, revealing the widespread dearth of health education for drug users in the community. She really feels like she was only properly educated about Hepatitis C and other health conditions she had while she was in prison in her 40s. She also learned in prison that “I didn’t know it took your body 18 months to two years for it to get back right.” She really felt gave her an extended period of time to finally feel “normal” in her body after years of opiate use. She emphasizes to me how important to her life that last time in prison was: “I think I wasn’t arrested, I was rescued this time, for real. You know, I wish I could have got this time before.” Not surprisingly, many women like Tina embrace these dominant discourses of punishment and individual responsibility that dictate the course of their lives, given that we all “regularly forget the economic and social conditions which make possible the ordinary order of practices” (Bourdieu 2000: 221).

Tina now has her own small one-bedroom apartment subsidized through the Boston Housing Authority in a trendy, fashionable part of Dorchester. Prior to that she lived for three years in a small, ten-woman sober house in Roxbury where she was the house manager. She was voted in recently as the vice-president of the community board of this building; she wants to clean up the building from the front-desk officers that sometimes have drugs or let drug dealers into the building. She has adopted two rambunctious children that are two and four-years-old whose father is legally blind and whose mother is an active heroin addict. They give her a reason to stay clean.

Yet Tina struggles with health issues that she felt were not well addressed in prison. Her medical conditions including kidney disease, Hepatitis C, high blood pressure, sleep apnea, chronic pain, anxiety, panic attacks, and PTSD. She has also been shot in the leg, stabbed in the neck and hit with a baseball bat by her ex-husband. She struggles with the ongoing trauma of her

murdered son and not being able to properly grieve and mourn the violence of his death; she struggles with the knowledge that the daughter she had with her father, who was raised by her own mother and father, is now out there “drinking and doing drugs,” refusing to do therapy with Tina.

Interestingly, Tina was put off by the idea of taking too many medications, particularly psychiatric medications. She worried that the medications were bad for her liver or her kidneys given her lupus. Her comments on this topic seem to almost reflect back to a previous era: “I sit here and I think back in the olden days they didn’t have medication for people to deal with.” She touts the AA line that “that’s just another substance” when she is told to take clonazepam when anxiety starts to well up inside her. She related how the jail told her that she was bipolar and gave her a pill that made her hair fall out (she stopped taking it). She attributed her mental instability to her situation; of course she felt “depressed” when she came into the prison because she was in withdrawal. Unlike many of the other women, who want any substance to help them ease the pain of detox, Tina did not want “medications to numb me.” She did not have easy access to a therapist even though she thought it would be useful. They told her after her son was murdered “since you don’t want to take the medications and stuff, you really don’t need to see anybody.”

Tina is by all accounts, to everyone that she encounters, a “success,” although her quest for well-being, like all of ours, is an ongoing project. Providers in drug treatment programs everywhere look for people like her in order to show how to successfully engage and utilize their services and programs. Tina credits a large part of her recovery to what Norman Neiberg had argued in previous decades as most therapeutic: a long-term relationship with a psychoanalyst, an older woman who has known her for the past five years. Tina also finds strength in God, in

the church she attends every week and in NA and AA meetings. In Tina's case, her success is a combination of a variety of forces including individual motivation; accessing high quality community treatment, including medication, therapy and residential drug treatment; encountering providers who treated her non judgmentally and kindly; community support from local church members and AA/NA meetings; and having hope and a reason for sobriety in the form of two young children who depend on her for everything.

How much of this can be attributed to the drug treatment she had in prison? It is impossible to tell. But Tina had been told she needed to "play the tapes" back to herself in her mind before she engaged in criminal thinking. Nevermind that this inward gazing stance does not recognize the oppressive macroeconomic forces in Tina's life; the prison programs largely views women as decontextualized, rational actors in which addiction is merely a bad choice. Casting Tina's situation as essentially a therapeutic concern also obviates recognizing the political economy of addiction and how addiction is a culturally mediated and produced affliction; her failures are her own moral responsibility and a reflection of low internal stores of strength and willpower. As the whiteboard in the group common space read, turning one's life of crime around entailed a mental shift in one's bad attitude and faulty lens on life: "Life is 10% what happens and 90% how we read it. We cannot change the inevitable!!!"

Going Back Home or Going to a House Full of Drugs and Guns

Brittany was another graduate of the WRA program. She had finally graduated from something. The staff at the program felt that she was setting herself up for failure since she decided that she did not want to go to a drug treatment program or a sober house. They recommend this option to most of the women, since the prison feels that an important part of succeeding after incarceration is having a stable place to go and from there being able to address

some of the social factors that led to criminal involvement and subsequent incarceration. Simply put, place matters. Where people return to in part vastly contributes to diverging outcomes, particularly between those who are allowed to go back to a stable place and those who are denied the possibility or have no home.

Yet home can be a complex and fraught notion for women who use drugs and struggle with addiction.⁷¹ In some cases though, family and “home” can provide a safe haven from not only drug use but also from the policing and supervision of the criminal justice system. Many of the women who left prison resumed drug use upon release, but only some were sheltered from being caught (Mae, for instance) and others were bound to systems of surveillance and punishment.

There is a strong rhetorical emphasis on the importance of the programs that women attend in the communities after prison. Once I attended a “program fair” at SMCC. Inmates milled about looking at a variety of programs across the state. Some women look for places near home while others try to flee their old stomping ground as part of their quests for sobriety. Yet while the prisons and jails emphasize the importance of programming, they do an erratic job of ensuring that women who want programs can get into them at the time of their discharge.

First of all, there are a limited number of treatment beds. Long-term beds are hard to come by. Sober houses are easier to find, and generally larger, than drug treatment programs. Most women have to be interviewed on the phone for admission to these programs. They have to state why they want to attend that program. There are also long wait lists for the good programs, up to six months or a year. Ensuring that a bed will be available on the exact day you are

⁷¹ And home is not synonymous with safety for many of the women I met. One 22-year-old woman who resumed heroin use quickly after her release from prison couldn’t go home because her father, also a heroin addict, had used drugs with her and her mother did not trust them together. She was homeless and couch-surfing when I met up with her after prison. And recall Mae, whose mother was waiting to pick her up from prison with heroin waiting for her in the car?

released and passing their interview process is a difficult task. And there are many things about your interview that could disqualify you from going there: your charge is violent; you have too many “mental health” issues; you don’t seem serious enough.

In Brittany’s case, she adamantly refused to go to a program or sober house after she left prison. When I see her a couple weeks before her “wrap” date, she is anxious about leaving prison:

Kim: The last time that we spoke you really wanted to go home and that’s what you thought you needed to stay clean. Why can’t you go home?

Brittany: She [her mother] is not letting me go home. Absolutely not.

Kim: Why not?

Brittany: Because she’s insane! I don’t know. She’s insane. She’s stuck. She has it in her head that me coming home would just be horrible, a horrible idea.

Kim: What does she think you’re going to do?

Brittany: She thinks I’m going to use, she thinks I’m going to overdose, she thinks that I’m just going to be at the house getting nothing done, she doesn’t want to have to deal with it. She doesn’t want to have to be my taxi. She has a life, she doesn’t want to have to “worry about me overdosing in my bed,” those were her exact words. She’s like harsh with it, she really does not care. “You’ve ruined my life for the past 6 years.” She’s kind of dysfunctional, we’re going to fight.

Brittany mulls over the possibilities. She is currently talking to three different guys from her past. She halfheartedly asserts that she wants avoid catching a “wicked bad habit.” The wheels turn rapidly in her mind about who is the best positioned to give her a place to stay when she is released. There is Corey, who is a drug dealer in one of the prosperous white Boston neighborhoods. He loves Brittany and he readily supplies her drugs. He has been trying to get clean—“one shot of dope in the morning and he’s not doing ten more shots throughout the day, just one in the morning and taking clonidine at night to sleep.”

Then there is Nick, Brittany’s most recent boyfriend. They haven’t talked for the last six or seven months while she’s been incarcerated, but they started talking now that Brittany is getting ready to leave. He lives only five minutes away from her mom’s house, so that would be

perfect for her. Nick wasn't a heroin addict ("he was an alcoholic and he'll eat benzos sometimes"), so that was potentially better than going to stay with Corey.

There is also Paul who introduced Brittany to selling drugs when she was sixteen-years-old. Brittany's mother hates Paul. Recently there has been some tension, since Paul has been visiting her in prison and Brittany's mother found out and threatened to "not take care" of her (stop putting money into Brittany's canteen) if Paul kept coming to see her. Paul had offered to get her an apartment, a place to stay. Brittany is anxious. "I want to do the right thing," she protests.

Brittany's counselor in the WRA program is helping her look for "transitional living type situations" like sober houses. She tries to explain to me why she won't go to a sober house:

Brittany: And I hate that. Transitional living, whatever you call it, I hate it.

Kim: You're not going to stay?

Brittany: I know I'm not. But just to know that I do have that...

Kim: Have you done that before?

Brittany: No I haven't.

Kim: Okay, so why do you know you're going to hate it?

Brittany: Just because I don't like programs. I don't. I don't like it.

Kim: You don't like not having the freedom?

Brittany: Yeah. The assigned room, I'm like, no... I don't want an assigned bed. I'm sick of it you know.

Kim: Too much like prison?

Brittany: Yeah. I don't even know. I hate it. I hate it. I'll do outpatient program all day, no problem with that. I'll go to a counselor, anything. Put me in a sober house or inpatient program it sounds like torture to me. Absolute torture.

Kim: Putting up with all the rules?

Brittany: Just everything, yeah. It's like not what I want to do at all. Like I definitely wouldn't be there because I wanted to be there, at all. I wouldn't even be there for any of the right reasons.

It becomes clear as we talk that Brittany's mom wants her to go to a long-term drug treatment program, or as Brittany phrases it, "She wants me locked away in a program for the rest of my life!" For Brittany, her nine-month stint in prison is a reason to explicitly not go to a

program. Why does she need drug treatment when she just completed a six-month residential drug treatment program at the prison?

Her hyperbole is no exaggeration to her. Her feelings resisting the idea of more drug treatment are too important to dismiss; they must be reckoned with as legitimate, that truly influence her decision about where to go. Brittany feels so anxious about her prospects that she is having trouble sleeping and is having dreams about using drugs. She tells me that she feels like everyone is “setting me up to fail and to use and to go back selling drugs.” That will be the reality of the situation if she goes to stay with Corey, Nick or Paul. In her mind, she refuses a sober house for the rules but also for the loneliness: “I don’t like being alone. I hate being alone. I never liked being at home.”

While she says she wants to avoid using drugs, half of her wants to, and the anxiety she feels about being released is part and parcel of her desire to get high. “Honestly, I just want to get high,” she tells me. “I know it’s bad.” Even though she has to check in with probation, she assumes she will use and then try to flush her system by drinking lots of water several days before she goes to check in. She imagines that she will eventually start selling drugs again “just to pay for probation [fees] each month.” I am not sure what kind of life she envisions for herself, although she has told me before that she hopes in fifteen years to “have a family, and [be] working, living in a house.”

The next time I see Brittany, I pick her up at a house “full of drugs and guns” in a far southern part of the state, a little bit over an hour away from Boston and past the stadium where the Patriots play. She gives me the address of a house on the street, but not actually the house

that she is staying at. I wait on the front porch of the wrong house while she straightens her hair several houses away. The town is sleepy, working-class, suspicious of my Asian otherness.

On our way to a Dunkin' Donuts where she used to deal drugs, Brittany unleashes all of what has happened to her since she got out of prison. Her dad picked her up the day she was released and got her a cell phone and paid for a hotel for her to stay in for two weeks. The plan was that she would then go live with Paul, who had offered her a place to stay but it wasn't ready yet. The first night she stayed in the hotel, her ex-boyfriend Nick came over to the hotel. He had become a full-fledged heroin addict, looking now "all junked out," a derogatory term for a strung-out, emaciated heroin addict. They get high together, and the next day Paul comes over with a friend, Johnny. She starts "hanging out" with Johnny, who also sells. The next night, Corey comes over from the white, upper-middle class neighborhood in Boston. It turns out that Corey is "still a raging addict, but he's not selling anymore like he used to because he's being watched... he's only selling shit kind of, pretty much just to support his habit." Brittany is upset because when Corey comes over "he doesn't even have dope and he's nodding out on benzos the whole time." Brittany is pissed. They go up to Boston the next day, score some drugs, and come back to the hotel.

Brittany ends up sleeping with Johnny, who "wants me to be his girlfriend." She is irritated because she doesn't want to be anyone's "girl." As she explains, "I just got out of jail, I need to get my shit together, I'm not going to be in any sort of relationship now. Mind you, I wasn't even attracted to him, so it's like, a dead issue." Johnny lets her stay at his house, although it is not a pleasant situation for Brittany: "I just wanted to be high the whole time, because I didn't even want to be there. I just wanted to stay high. He'd go out, make plays all day [do drug deals]. [He would ask] do you want to come, do you want to come? Nope, nope,

I'm good. I just want to stay in this room, in a coma, please. I want to be comatose, I don't even want to be awake right now."

She is so unhappy with her living situation—exchanging sex for drugs—that she falls back on her friend Tracy whom she met while she was in prison. She heads to Salem, Massachusetts, but is disgusted by them because "they're all junked out." The first night she is there "they're already asking me for money, to go cash in my Food Stamps for money. I'm like, I don't do that. I actually use my Food Stamps for food... especially since I'm homeless and bouncing around." She leaves to go back to her father's house.

Her stepmother does not really want her around, so she heads to the house of an older woman named Janet. Brittany's father gives Janet \$400 to let Brittany stay there, and she sleeps on the blow-up mattress in the same room as Janet's 17-year-old son. "Janet is jammed on Perc5s" even though "those are huge with tylenol in them, it's disgusting, to be sniffing them." They also get in fights over Food Stamps. While she is staying there, a two-year-old who is also staying at Janet's house accidentally eats half of a suboxone tablet that they had given to Brittany "because I was trying to get clean." No one wanted to bring him to the hospital, because they were worried that DCF [Department of Children and Families] would become involved. They tried to get the boy to throw up the pill. "We let him sleep and would wake him up every 20 minutes." Finally, he throws it up. Janet finds a needle in the house and forces Brittany to leave.

Johnny comes to pick her up from Janet's house and she has been staying with Johnny ever since. She knows it's dangerous to stay in Johnny's house, but she feels like she has limited options. "The cops, they want him so bad. He has two open cases for Class A, and Class B, that are still open. They're non-stop partying, they're always fighting people in the parking lot. The cops show up here, they'll ask us about guns. They know we don't even have any guns. Well we

do, but they don't know that we do." She tells Johnny he needs to "obviously take a break, retard" and get a new phone number, "you can't be greedy with it." Brittany herself was taking a forced hiatus from dealing. She had lost her phone, had no contacts and no car. She couldn't sign onto her Facebook account because she forgot the password and had used a fake email address.

Much has changed in her town since her stint in prison. "Pills are hard to come by now, they're not as free flowing as when I went to jail. I was picking up 100 a day, and eating all of them... But everyone I know is shooting now. I pretty much got everyone hooked on [percs]. Everyone is shooting up now [a year later]." She tells me a little bit about how easy it is to become a small-time drug dealer. I ask how much money she needs to save up, \$500? She laughs, "Not even. You get can a quarter of dope for like 200 bucks, and flip it." You could double your money if you didn't do any of it yourself. When Brittany dealt, she sold Perc30s, but at the time she was using dope, so she was "saving money." It was a smart move for her because the Percs were more expensive, not as powerful a high, and didn't last as long as heroin.

Brittany planned to go live with her father in Vermont. He had gotten her a job in shipping and packing at his company. Even though she had to report to probation—which she felt kept her in line—she managed to work it out so that she would have urines taken at her father's company and send the results to the probation officer. She was too poor to have enough money to get a serious habit; her ability to get heroin was too erratic: "I should be dopesick right now, I haven't used in two days, and I'm not [dopesick]. I just can't afford it."

Brittany's outlook on life was dismal. When I asked her what she was most worried about in her life, she told me, "Probably that I'm not going to stay clean. At this point, I've already been to jail and done the whole thing. At this point, I think if anything's going to happen, I'm going to end up dead from it...I don't see me going back to jail." She used drugs not to self-

medicate—she told me she would use drugs if she was feeling happy, sad, bored, lonely, scared, mad, it didn't matter. She wasn't scared of dying, she just hated the feeling of being clean and sober.

When I last talked to Brittany, she told me she developed a “wicked habit” in New Hampshire. She left for her ex-boyfriend's house, got “strung out there,” hit up Paul's house, overdosed and then went to detox. She went from there to a 28-day program for women in Boston, then to a halfway house in Cambridge for women. She left there and overdosed again, spent 10 days in a psychiatric hospital and entered another program. She is actually hoping to get clean this time.

Part of what made Brittany different from some of the other women in my study was her relative youth. Young women in their adolescence or their twenties are seen as a particularly difficult group to treat. Simply put, they just don't really want sobriety. They are young, relatively healthy and pretty, all of which allows them to traverse drug-using circles easily. They might not have serious obligations to family and might not have had children yet.

I want to contrast Brittany's story with the story of Faith Gomes, a 29-year-old woman of mixed Cape-Verdean-Caucasian descent whom I met in SMCC. Like Brittany, she had intense anxiety about leaving. She blamed the prison for not doing anything to help her. She was returning to Brockton, a small big town south of Boston known for drugs and its relative impoverishment. She had previously “run” (used drugs) in Brockton as well as in Fall River/Taunton area. Faith had been seriously ill from her heroin addiction, with blood infections and pulmonary lesions and pneumonia in 2011. She was “having people bring me dope and I was shooting it through my PICC line the whole time I was in the hospital because I just had to have it.” She used to watch where the nurse would drop the needles and retrieve them and shoot dope

out of the same needle that they had used to administer her medicines. She also inherited a house and over \$100,000 her grandmother had saved for her upon her grandmother's death. She bought a car with that money and spent the rest on drugs. The house quickly became a drug house, open for all.

I sat in on one of the discharge planning meets at the SMCC known as the "triage" meeting. The various parties—medical discharge, correctional officers, psychiatry, some community providers, parole, and the WRA drug treatment staff—met once a month in order to discuss all the women who were nearing release. Faith was several months away from a release date when they discussed her, but she was causing trouble. According to the WRA staff, she was in a relationship and she got kicked out of the WRA program by making "indirect threats," which is "breaking an Absolute Rule." The woman who ran the WRA program could, as a result, no longer work with Faith on her discharge plans. She tells me that Faith is "self-sabotaging" herself because she wants to go home instead of going to a drug treatment program. Faith is particularly set on going home in order to be with her little boy, Dante. The staff at the prison had been trying to convince Faith that if her child is in a stable, safe situation while she is in prison that she should prioritize her recovery from drugs by going to a program before she prioritizes a reunion with him.

When I talk to Faith, she denies she is in a relationship and claims that all her friends happen to be "butch." She is upset that she cannot work with the woman from the WRA program because she trusted and liked her. Now the woman just sails by her in the hallways and pretends not to see her. Faith gets on a waiting list to enter a program with her son in Charlestown. This program is a small, family-based drug treatment program allowing women and their children to live at the house for up to a year. Faith gets her name on the waiting list but she is supposed to

call every couple of weeks in order to stay on the list to show interest and provide evidence of clean urines; there is an estimated six-month to a year-long wait list.

Faith wants to go “home,” but it is not clear where she will stay. The house has fallen into disrepair, according to her father. Her aunt in Brockton who has temporary custody of her son allows her to come stay for a short while there. Faith breaks down and cries when she talks to me. She has all kinds of things she wants to do: get a job, go to the doctor, get her son, get her license back, fix the house, get a car. It is overwhelming. On top of that is drug use. I talk to her about possibly getting on suboxone to help her physically subdue cravings.

When I meet Faith in Brockton a week after her release, she is staying with her aunt and her son. She has not used, not even a cigarette she says. She is fixing up her house with the help of her friends, since her Aunt has Section 8 housing and has given her only a couple of weeks to stay. I ask her why hasn’t she used—this is her stomping ground, and she could obviously have picked up if she wanted. She tells me, “Don’t get me wrong, it crosses my mind an awful lot, but I think I’m really just, I’m tired. I know what it does to me. I can’t just do it once. I’ll go get even a \$20 [bag] right now and later tonight I’ll be wanting a \$50, and then tomorrow I’ll want \$100. And then before you know it I’ll be back in jail, I’ll be sick as a dog, I won’t have my son.” So, I ask, there’s just too much at stake for you to use? She tells me, “My house is almost [gone]...it’s hanging by a thread. If I go out one more time, it will be gone. I spend so much time with my son. And I love him. And he’s so fun and we laugh and we hang out and he’s getting used to me. Because that was a big thing, he didn’t want no part of me. He’d cry and go to my aunt. That was hard for me.”

So Faith, despite all the predictions of treatment staff at the prison, and despite my cynicism, is “successful” of her own accord. She is going to the doctor’s appointments that I set

up for her and is healthy and well. She is “doing good” finally, in the process of creating a relationship with her son and learning how to be a mother. Yet her “re-entry” is tenuous. She continues to remain in a class of society that is always just barely getting by, somehow cobbling together social, financial and physical resources to have enough for the present.⁷²

One thing Faith has is hope. She sees it everyday in the chubby cheek and cries of her son. Even though he does not yet know her, he will soon. He has grown immensely: from a 6-month-old baby to 16 months. She says of Dante, her “little slice of heaven”: “I need him more than he needs me. And people are like, well you keep saying, he can’t keep you sober, he can’t keep you sober, but I’m so thirsty for him. I feel like he could... Because I just feel like I need him to breathe.”

Suffolk County House of Corrections’ Drug Treatment

The jail has a different kind of approach to drug treatment and a slightly different set of drug-related problems than the prison. For the female inmates at Suffolk County House of Corrections (SCHOC) in Boston, drug treatment is a relatively minor aspect of the programming there. The women’s unit is located on the top three floors of the relatively new jail facility that was constructed in the 1990s. The facility recently suffered from shoddy construction that resulted in day-to-day problems for the women on these floors. The ceiling tiles leaked, dripping rainwater into the unit and into administrative offices. The jail struggled with space constraints and design problems. Some of the units on the women’s unit were constructed without toilets in the cells (known as “dry cells”) and the women constantly barraged the guards with requests to use the communal restroom. The communal restroom was a source of potential danger and

⁷² Faith is also surprisingly prospering with the help of the Division of Children and Families (DCF). DCF is generally a much-maligned arm of the welfare state for taking children away from families in trouble, families that are deemed “dangerous” or potentially harmful to children. Yet DCF is helping Faith: helping set up counseling, helping keep her on track, helping her get fuel assistance for her house.

wrongdoing on both the part of the inmates and the guards: it was a place to congregate, to engage in surreptitious activity (sex and drugs), to exchange bits of information back and forth.⁷³ These units attracted guards who were sometimes less than aboveboard in their intentions and behaviors, so the women's unit was undergoing construction to install toilets in all the cells.

The Suffolk County House of Corrections, the 30th largest criminal justice facility in the country, must deal with being a jail that houses both women and men but predominantly men. It overflows at the seams with men, the men sometimes triple bunking in rooms. Historically, when men and women were housed in the same facilities, women tended to get short shrift because of their relatively small numbers; even Alexis de Tocqueville commented on the extreme neglect of women prisoners. Housing both sexes makes the work of the jail even more difficult than prisons especially since there are shared facilities like the infirmary. It makes movement and population control difficult. One of the women in my study told me, "We don't move around like they do [the men]. It's their jail."

The first female Sheriff, Andrea Cabral, set to turn her attention to the plight of the women. Her predecessor, Sheriff Richard Rouse, had taken a buy-out for corruption and patronage; during his tenure, a female inmate became pregnant and sued the jail for sexual abuse, there was rampant sexual abuse, an inmate died of a heroin overdose and inmates were beaten by guards. Cabral had an interest in women from her tenure prosecuting domestic violence cases in the Attorney General's office. According to her office, under her leadership the jail had

implemented mandatory, gender-specific inmate programming for female inmates and pre-trial detainees. This programming addresses the different issues and barriers to post-release success that confront female ex-offenders. Using a comprehensive intake process, programs that target the specific deficits (education, substance abuse, unemployment, trauma-based mental health issues, etc.) and

⁷³ A report from the United States Attorney Donald K. Stern prepared for Governor Jane Swift, entitled the Special Commission on the Suffolk County Sheriff's Department, in 2002 noted one of the problems with dry cells was that it was "neither possible nor practical to lock the rooms at night. Thus, inmates routinely will be out of their dorms after "lockdown," and opportunities for staff to be alone with inmates in office areas and other isolated areas outside the coverage of cameras" (Stern et al. 2002: 24).

solid discharge planning, every female inmate and pre-trial detainee has access to effective pre-and post-release programs and services, including post-release housing and employment (Cabral 2010: 8).

I met the Sheriff, a beautiful yet imposing figure, once at a meeting several years back. She waxed eloquent about the plight of women in jail: “In my opinion, this is where the rubber hits the road... women are alone. Women are alone with their children. They are still in these kids’ lives. We need sustainable long-term aftercare. We’ve been missing the boat for years and this will come back to haunt us. This should save money not only in the cost of corrections, but in the cost of human potential in wasted lives.” Remarking on her time as a prosecutor of domestic violence crimes, she wondered aloud about the differences between the women that tend to turn “inward” and those that turned “criminal.” She felt that women were different and needed different kinds of programming than the men: “When we first decided to do ‘gender specific programming,’ women get so much out of it based on the relationships they make—continuum, not compartmentalization, like the men.” She seemed to recognize women’s relationality, an ethic of care and interdependence (Gilligan 1993; Noddings 2003). Yet how could such an ethic of care based on relationality and the lived experiences of women’s lives be actualized in the sterile punishing concrete blocks of the prison?

Even with a renewed attention to the plight of women, the jail suffered from some other kinds of problems unique to detaining people for short periods of time. It struggled to keep up with at least three populations of women with different kinds of requirements: the pre-trial population (the awaiting trial unit), the sentenced women, and the federal immigration (ICE) detainees. The vast majority of the women were pre-trial detainees with entirely unpredictable lengths of stay. Their case could be continued, be seen in court in two or three more months, or the case could be dropped or dismissed, and the woman might be released straight from jail. The case could also drag on for years.

With a rapidly cycling population, it was difficult to offer comprehensive treatment. The jail in many ways was more “local” than the prison, coming to know over long periods of time many “regulars.” Some guards grew up with the women, starting their jobs at the same age these women started going to jail. Some expressed deep feelings of sadness at witnessing the chronic cycling the women experienced. During the summer, the police conducted a big raid in Chelsea, a small neighborhood to the north of Boston, and the regular “girls” were hauled back in. The guard told them how bad they looked: “You were saved from yourselves, to be here. Go look in the mirror. One of them told me, yeah, you’re right. They start looking better in a few weeks, but they go out and wreck themselves again. That’s how powerful this disease is,” she concluded. The next time the jail staff see her, she might be ninety pounds, gaunt, track marks streaking her arms and thin frame.

During Sheriff Cabral’s tenure, the jail applied for a grant and won money to focus on women deemed “dual diagnosis” (mental health and substance use disorders) and a program called the Suffolk County Female Offender Mental Health Collaborative was born. The grant was a two-year program and employed two female social workers to conduct the screenings and the follow-up. According to the designers of the grant, women have a particular combination of unfulfilled needs that lead them to prison and thus necessitate a different approach than men:

“Currently there is no systematic way to screen for mental illness, identify needs, provide treatment, pre-release, and ensure that the woman follow through on her post-release treatment plan. The goal of the Suffolk County Female Offender Mental Health Collaborative (SCFOMHC) is to scale up mental health and related services provided by the Suffolk County Sheriff’s Department who have been diagnosed as having mental illness or co-occurring mental health and substance abuse disorder and who have faced, are facing, or could face criminal charges for a misdemeanor or a nonviolent offense” (October 10, 2012 Data Update).⁷⁴

⁷⁴ Interestingly, women with violent offenses were not included in the original grant, although services were extended to include these women at a later date. The issue of “violent” offenses is a touch-stone. I met many women accused of or convicted of “violent” offenses, often assault and battery, and they seemed no less deserving or worthy of services than any of the other women I met. I became suspicious throughout my fieldwork of charges and took them with a grain of salt.

The goal of the grant was to see if identifying dual diagnosis women and giving them extra support upon release would decrease recidivism. They hoped to target eighty dual-diagnosis women who were either detained or sentenced (although women who were not sentenced and generally were awaiting trial tended to be harder to provide services for given the uncertain time frame). The treatment included a comprehensive mental health intake, individual treatment plans, transitional needs assessments (for discharge), setting up women with appointments for care in the community, and a 30-day follow-up. They hoped that the women would want to "check-in" with them upon their release. At one of the data update meetings, someone asked about how successful they were getting in touch with the women. One of the social workers made a face, grimacing in response—the rate of successful follow-up was extremely low.⁷⁵

The two grant social workers also did some work in the community trying to work with women upon their release. One of them held a weekly meeting at the McGrath House, the pre-release program for women in Boston who were paroled there before they were released entirely (these meetings stopped after McGrath House suffered turmoil in administration and a change of leadership). They also noted that a smaller number of women were placed on suicide watch "because of the stronger mental health presence."

They found that female offenders at SHOC recidivated at 41% in one year versus a rate of 49% for inmates in all the institutions in the Massachusetts House of Corrections Sentencing

⁷⁵ As part of this grant, the SCHOC Women's Department hosted meetings every three to four months with the community partners who were interested in the problem of female incarceration and their barriers to successful re-entry. The meetings were attended by a motley crew of people from probation; Department of Mental Health; Project Place/CREW; Shattuck Hospital; parole, one time; Community Supervision Department; mental health caseworkers from the jail; a representative from the Mental Health court in Roxbury; Roxcomp (Health Center in Roxbury, before it closed down). It is not clear why some organizations have come to the meeting and why others have not. I naively ask why SPAN, a well-known and dedicated social service organization for people with histories of incarceration in Boston, is not here. The answer I got was that "they are kind of competitors with us, like they compete for grants with us and Project Place." I begin to see glimpses of how extremely political this world is.

Commission. Within three years, 45% of the females had "no new crimes" as opposed to 40% for women in a federal study. The data they collected on the women showed that many had mental health disorders, the most common of which were PTSD (50%), opioid dependence (48%), cocaine dependence (31%), depression (30%) and bipolar disorder (18%). 32% of the women in the study had three or more mental health diagnoses, 33% had two, and 23% had one. The program assessed women and tried to come up with a case plan that took into account "gender-specific criminogenic factors," including: mental health history; depression/anxiety, psychosis, child abuse; adult victimization; relationship dysfunction; parental stress; and housing stress.

The social workers at the jail administer three assessments, including a comprehensive initial interview, a transitional needs survey and a re-admission questionnaire (if a woman returned to the facility). The interviews touch on why women think they were incarcerated, what forms of supports they have in the community, and what it meant to stay healthy. Inmates are asked questions like, "Think about a time that you were clean and happy on the outside. What helped you to feel stable at that time?" and "What services/programs do you think would be helpful to you on the outside?" in order to find specific programming for individual women both inside and outside of the jail.

The drug treatment programming happens on the eleventh floor of the jail with the rest of the women's programming occurs. There are classrooms on both sides of the hallway where the elevators frame the central corridor of the jail that lead to the units where women live. The programming guard has a list of names of women who are signed up for each particular class and the women from each unit come over to her and give her their ID cards as they enter class. The large airy room where the guard sits is full of posters and cheery signage, and the flanking classrooms are decorated in a similar fashion. Posters showing a pregnant woman's profile warn

about getting tested for HIV and Hepatitis C. Individual desks that look like they belong in an elementary school library ring the main space. Space is always a constraint up on this floor.⁷⁶

Women who come into the jail are required to participate in a two-week mandatory set of classes. Classes are taught in two phases and cycle by the week with graduation at the end of the two weeks. General topic areas that run throughout the four weeks are: Recovery and Re-entry: Life Skills sections in the morning, Domestic Violence and Anger Management in the afternoon.⁷⁷ It is a blitz of programming taught by external contractors, staff and caseworkers in the women's department and even correctional staff. After the women are done with these mandatory classes, they can take a wide variety of other courses, including: Freedom From Violence; Domestic Violence; Recovery 101; Risky Business; Yoga; CREW; Bible Study; NA; Book Club; Digital Toolbox; Anger Management; Music Appreciation; Writing.⁷⁸ In one of the classrooms that looks out south at South Bay Shopping Mall—where the Target, the orange Home Depot, glisten in the distance in its concrete sprawl, like a real mirage—there is a handwritten sign that reads, “Remember if you stay doing what got you here, you’ll be here/if you strive for your goals/you will succeed, you will not return here.”

Part of the problem inherent in providing inmates “treatment” is the contradictions and hostility from the officers. Donald Stern, United States District Attorney, wrote in his 88-page

⁷⁶ One time, I am conducting an individual interview in one of the classrooms and the meditation class has to come in. Another time I am in that classroom and am interrupted by a correctional officer opening up a closet for the work release women as they load candy and chips into their baggy uniforms as a reward for a job well done.

⁷⁷ Topic areas within the first week include: Family Disease of Addiction; Parenting; Female Empowerment; Self-Monitoring; Entitlement Thinking and the Link to Anger; Errors in Criminal Addictive Thinking; Feelings; Success is a Thinking Skill: Decision-Making; Post-Traumatic Stress Disorder and Battered Women Syndrome; Legal Issues; and Learning About Yourself. During the second week, topic areas include education about health; Becoming Undependent; Health Relationships; Interviewing Do's and Don'ts and Dress for Success; Assessments and Relapse Prevention Management; Safety Planning; Self Esteem, Humility and Spirituality; Keeping the Job; Success Stories; Aftercare.

⁷⁸ Many women sadly don't have the opportunities to engage in these kinds of leisure activities or educational activities on the outside. Their lives are too hectic and they don't have the resources or the energy to seek out these seemingly unnecessary outlets. In jail, they have nothing but time. Much of this programming and coursework inevitably turns to issues of substance use, but they cannot afford prolonged programs since the average length of stay is so short.

report on the Suffolk House of Corrections' that officers expressly opposed programming. As he wrote in this report:

Separate halfway houses now exist for men and women released from the HOC. A women's resource center day reporting program provides services to female offenders in the halfway house... Budgetary cutbacks regrettably have slowed these measures. Even more regrettable is the strong opposition to inmate programs from the officers' unions" (Stern et al. 2002: 21).

He claimed that the missions and the means of rehabilitation and treatment were expressly opposed by correctional officers' unions, making explicit that the non-recovery and the non-rehabilitation of inmates was a source of very real job security for officers: "Modern corrections recognizes the importance of inmate programs to the overall mission of the Department [of Corrections]; the custodial staff of the Department does not" (Stern et al. 2002: 9).

The Dilemmas of Prison-Based Drug Treatment

Much of the drug treatment programming offered in prisons and jails just did not take. For example, at the WRA program, women did not necessarily embrace joining a metaphorical family when the majority of them have their own children and others they considered family. The very fact of being incarcerated was an abdication of the role of mother or wife or girlfriend or daughter. It was a failure to fulfill very real social roles that caused them pain and guilt.

Prison, by its very nature, is about alienation. The drug-treatment programs stress freedom as a theme. Freedom from substances is obviously the most compelling notion, but also just the chance to be out and free in the world. It is inspiring and self-empowering to imagine one's life, freed from prison, from harmful substance use, free to live as one pleases, free from the threat of police or arrest. Unfortunately, for the majority of women who are incarcerated and in drug-treatment programs, their lives after prison will not include such freedoms. This is partly

the stigma of incarceration and the damage it has on individuals and their communities, uprooting individuals and creating tension, strain, distance, hostility, shame and guilt.

But it is partly a lack of opportunity. Anne Morrison Piehl, in a review of the Massachusetts jail and prison system, noted that programming was not supported and that education, an evidence-based pathway out of incarceration, was scarce: she found that the Division of Inmate Training and Education saw budget cuts from 5.33 million in 2001 to \$3.72 million in 2004, with 36 full-time prison teaching jobs cut. She also found that the number of women participating in family services dropped 60% and the waiting list for drug treatment at the Correctional Recovery Academy had over 500 inmates (Piehl 2005:4).

Drug treatment programs in prisons and jails do little to address the structural violence that has largely defined these women's lives and the prison represents a further mark of stigma and shame. Prison- and jail-based treatment programs cannot "treat" the desire to dissociate from the world that is the precise reason why so many women turn to heroin, seeking oblivion and disconnection. And very few women are able to actually utilize their newly acquire cognitive-behavioral tools and techniques under the stress of homelessness, lack of income or strained family relationships upon release. As Arthur Kleinman has suggested, "Some things do matter, matter greatly—such as status, relationships, resources, ultimate meanings, one's being-in-the-world and one's being-unto-death and transcendence, among many other things" (1997: 362). What would such a program even look like, that could simultaneously account for these immeasurable intangibles (the need for companionship, intimacy, relaxation, fun, healing) as well as the macro political-economic forces that bear down on these women?

Prison programs differ significantly in many ways from their community counterparts. One of the most obvious is that in the community people can leave of their own accord. It allows

them some agency, some sense of control, even to make bad decisions. Undergoing treatment takes some effort and prioritization; women have to want to be clean, just a little bit. In the prison, the drug treatment program, while voluntary, has coercive elements. It is a prison, after all. Making a bad decision (for example, to use drugs that are available in the prison) can result in a disciplinary-report, being sent to the Close Custody Unit/CCU/“the Hole” and being dropped immediately from treatment (even though it is taught that addiction is a relapsing, remitting disorder marked by slips).

Everything about prison is a construct, it is artificial, no matter how much of the same treatment literature is utilized there. The relationships that people have with staff or counselors, or even friendships or romantic relationships, they tend to be fleeting and transient. Even if women “do good” at treatment, like Brittany, who never used drugs once inside (“I was too scared” said this rebellious young troublemaker who could not control her desire to be high all the time when she was released), her abstinence is a by-product of a combination of rules and regulations that does not exist in the community. Although drug treatment programs in the community can have their own seemingly arbitrary or harsh rules, it more closely mimics the reality of their lives. One of the women in my study, Jane, relapsed to heroin use after she let a drug dealer stay at her apartment. She went into a 28-day residential treatment program, but was not completely separated from her life. She could still attend court dates for custody of her children, she saw her children every weekend, and she could still go to her doctors’ appointments. Her sobriety was her own and it was her choice. It was a closer approximation of her “real” life, the “real” context of her drug use.

Well-Being, Self-Care and Metrics of Success

In evaluating drug treatment programs, common metrics of success include recidivism (for the prisons and jails, perhaps the number one most important factor); relapse and return to drug use (both self-report and urinalysis); employment rates; criminal behaviors; seeking out other drug treatment programs ("aftercare"); even measuring so-called "pro-social" attitudes.⁷⁹ These are the quantifiable markers of success. Recidivism is the number one concern, where the money is (literally). Research on prison-based therapeutic communities have been "associated with reduced re-arrest and reconviction rates and with better parole outcomes" (Hiller et al. 2006: 739).

Yet what do women think of as success after completing these programs, after leaving prison? How do they measure the impact of prisons on their lives, on their chances at well-being, happiness, health? For most women, they valued the time the prison gave them for self-reflection and education. Upon release, their health was a fairly low priority. I hoped that they would advocate for programs that would actually start them on opioid maintenance therapy a couple weeks or a month prior to release from prison, making the immediate aftermath of release less risky for overdose. This seemed like a humane and reasonable medical approach to me but was too radical and costly and a shocking idea to prison administrators. Many women said they would have embraced such a program, but just as many thought that they would throw away their new-found, prison-based abstinence for a medication that they would still have to "be sick" from.

While they wanted quality healthcare, including drug treatment, they even more desperately wanted some kind of absolution, a way to holistically attend to their bodies, their minds, their ongoing traumas, their sense of guilt and shame at being incarcerated, separated

⁷⁹ According to the Women's Recovery Academy, "pro-social" means "having a positive attitude about being with people, wanting to be helpful to others and having a positive attitude about society. Your own well-being depends on how well you contribute to and interact with others."

from children. One program offered in the prison seemed to offer ways for women to "work" on themselves: the yogaHOPE's Trauma Informed Mind Body (TIMBo) program. The TIMBo program "was developed specifically for women suffering from chronic trauma, addiction and/or abuse and offers women the tools needed to address the psycho-social, emotional, and physiological root causes, and enabling the to heal from trauma and to improve emotional regulation."

After completing the eight-week program, most women in prison noted significantly lower symptoms of anxiety and trauma as well as an increase in writing/journaling, meditation, yoga practice and self-talk. One participant told the staff, "I have re-found my faith in myself and my confidence. Life hasn't been as much of a struggle." The TIMBo program utilizes the yogic philosophy that there is a deep connection between the body and the mind. Advocating a standpoint of having compassion for oneself and living in the present, the philosophy emphasizes ongoing self-care, healing and mindfulness. It tries to address the deficit in self-care that so many women in prison engage in while taking care of others.

The TIMBo program gives women some embodied ways to actualize working through emotions. Yet emotional and spiritual growth in the context of ongoing structural violence is a difficult place to be. The Women's Recovery Academy program stresses that "recovery is a growth process of overcoming both substance abuse and criminal behavior. Recovery is making lifestyle changes." They emphasize it "is possible for just about anyone who really wants it and works at it." Unfortunately, even undergoing the six-month treatment at the prison or even shorter stints of treatment at the jail just cannot erode years or habits and ways of adapting to lives of hardship. Drug treatment experts emphasize that even the best treatment can often be a multiple-year process, with slips and relapses built into the model of the process. Few people get

this kind of care and being incarcerated can be a significant slip for many women seeking sobriety in the community.

And ongoing drug use is not necessarily synonymous with suffering. For many, it is a way of seizing small moments of pleasure, escape, oblivion. As feminist sociologist Elizabeth Ettorre writes, “In this context we can see that within the emotional economy of drug use, pleasure is distributed sparingly as a form of property” (2007: 139). Drug-using women are largely seen as undeserving of pleasure and that is “why it is crucial for her to embody what little pleasure she can” especially “if poverty, violence, poor health and depression intersection with her embodied life” (ibid).

While drug use can be one small source of pleasure, the majority of women don’t define happiness as having a needle in their arms. They also tend not to define themselves by abjection, suffering, hardship or trauma, although these aspects certainly are components of many of their lives. They seek out and cling to the small moments that make life worthwhile. Faith gets to sleep with her chubby baby she calls her angel as he squirms the whole night. She can delight in taking a video on her cellphone of how he is scared of walking on the grass. Memories and thoughts of children can either be great motivators or else cause great pain.

Children play a large part within this political economy of hope that is often foreclosed by the prison. Carol, for example, yearns for being with her four children all together: “The only thing I want in my life is to have all my children in the same place, have family dinners, sit down and have talks, know where everybody’s been, what they’ve gone through, what they’re hanging on to, who helped them through it because I wasn’t there, who is a part of that family... to be with all of us and just fucking know what life is.”

Others have given up on the vision of reunifications that cause them ongoing pain and guilt; Lisa, who was using heroin with her mother when her mother overdosed and died next to her, tells me, with a shrug, “Well I’m not getting my children back so there’s no need for me to be clean. I get to see them anyways, so it doesn’t matter if I’m clean or not.” She believes that addiction is her choice and that she is the only thing standing in the way of her sobriety: “When you’ve been through rehabilitation and jail, if you’ve been in a program, and you’ve been clean and you decide to go back, that is a choice.” She loves getting high, using whatever she can get her hands on (usually suboxone), even in the prison. She can foresee no life of sobriety either on the inside or the outside.

Chapter 5: Pain, Addiction and the Pharmaceutical-Prison Nexus

This chapter explores the relationship between pain, addiction, and the psychopharmaceutical/drug-using self. It attempts to place the subjectivities of actively using and recovering women in the context of a political economy of psycho-pharmaceuticals that seeks to profit from the medicalization of poverty and cultural shifts in distress and symptom management among the poor. Here I focus on the expanding market of addiction and pain pharmaceuticals, how pharmaceutical gamesmanship seeks to profit from the “non-recovery” and chronic disease models of pain and addiction, and how these maneuvers perpetuate invidious and often invisible suffering. Drawing on my fieldwork in three different sites— a suboxone clinic, a state women’s prison, and a jail that contains both men and women—I trace the social life of these pharmaceutical pills as well as street drugs as they literally traverse clinics, the streets, and prisons and jails (Appadurai 1986; van der Geest, Whyte, and Hardon 1996). I also attend to the increasing saturation of pharmaceutical companies into the space of the prison. With an estimated 7.6 million Americans struggling with opiate addiction, pharmaceutical companies that specialize in addiction products are heavily targeting spaces of abjection, including public clinics that serve the poor and multiply disabled, as well as prisons and jails, where an estimated 75% of inmates have lifetime prevalence of a drug or alcohol problems (Peters et al. 1998).

This is fieldwork conducted at what I am calling the *pharmaceutical-prison nexus*, that is, a set of entangled relationships and ties that is bound together by psychoactive substances and their effects in an era of entrenched poverty, mass incarceration and the forced confinement of

suffering bodies. Working at this interface allows me to pose important questions for anthropologists of drug use as well as students of social suffering more generally: how are psychoactive substances imagined, accessed and used in these abject spaces; how do they create or alter existing power dynamics; and how does the taking of drugs (or the decisions to not take drugs) affect one's very sense of self and the embodied experiences of incarceration and punishment? What part do these substances play in alleviating or prolonging suffering, as women "do time" and seek to get by?

Without question, pharmaceutical companies have been supplying the very stuff (the substances and compounds and increasingly the delivery mechanisms) that are the basis of an ever-expanding War on Drugs, including such pharmaceutical brands as OxyContin, Klonopin, Vicodin, Xanax, Percocet, Neurontin, suboxone, methadone and the list can go on in various permutations. These are the substances that have been flooding the streets via doctors with a wide range of intentions and relationships with patients. And these pharmaceutical companies have contributed to the further blurring of traditional boundaries of so-called licit and illicit drugs, since all these substances are various means to a desirable endpoint, oblivion. The medicalization of the so-called "War on Drugs"—with the promotion of drugs like methadone and suboxone as treatment options for opiate addiction—has only widened the criminal justice system's net, expanding the reach of police and prosecutors into (certain types of) people's medicine cabinets, purses, cars and houses.

This chapter seeks to illuminate the role that pharmaceutical companies play as they attempt to simultaneously profit off the War on Drugs, offering medico-legal solutions to addiction in the form of addiction therapeutics for patients and branding them as safer or less

risky formulations, while at the same time, they also downplay their own very active roles in over-promoting their products that flood communities with their pills (Singer 2008). And pharmaceutical companies are increasingly moving into spaces of poverty and medicalization like the prison.

Historically, pharmaceutical companies have treated prisons as places of experimentation, capitalizing on the social (in)utility and captivity of drug-addicted bodies. As Nancy Campbell reveals in her historical research on the federal addiction research facility in Lexington, Kentucky, the addiction researchers “were in the business of re-addicting prisoner patients for the sake of science... this determination provided information used by pharmaceutical companies seeking to bring drugs to market” (2007: 76). At least thirty-three pharmaceutical companies were active in the testing of a variety of 153 pharmaceutical and cosmetic products on prisoners in the infamous Holmesburg prison experiments in Pennsylvania between 1962 and 1966 (Hornblum 1998).

So the relationship between pharmaceutical companies and prisons is neither obscure nor particularly recent. Yet what is the contemporary nature of the prison-pharmaceutical liaison? Why is the prison—a place of deprivation and social abandonment of many of our poorest and sickest citizens—seen as a potentially lucrative market for pharmaceutical companies? For example, Alkermes Pharmaceuticals based in Waltham, Massachusetts, is engaged in early pilot programs that involve the free provision of Vivitrol injections for the treatment of alcohol or opiate dependence before individuals are released from prison. What are the implications of such enmeshment of “pharmaceutical gifts” into the lives of the poor?

What I posit here is that pharmaceutical companies are seeking to profit from cultural shifts in the medicalization of poverty and drug addiction. Like good corporations should, they

head to a logical space where poverty, poor health and drug addiction converge: the prisons. And much like Big Tobacco companies that have pioneered innovative techniques and epistemological maneuvers to capitalize on shifting public sentiments (Brandt 2009), pharmaceutical companies that deal in pain and addiction are at the beginning and the end of the line, adapting their corporate logics to respond to social problems that have originated with the widespread availability, use and “side effects” of their very own products.

“Endless Vicodin”: On Pain and Addiction

“For all the happiness mankind can gain is not in pleasure, but in rest from pain”-John Dryden, 17th-century English poet and literary critic

Eve Simon and I are sitting in a cavernous room in the Brockton Veterans Administration Hospital. Brockton is a town about twenty minutes south of Boston. It is well known for being a drug town. Eve is nervous; she has been asked to be the speaker at the Narcotics Anonymous meeting and she has invited me to come. She fidgets with her Narcotics Anonymous key ring, the one they give you when you have three months clean. There are maybe a hundred chairs arranged in rows, and filled by twenty-five or so people. It is a late meeting, 7 pm, and harsh fluorescent lights offset the dark curtain of night peeping through the windows behind the podium. Eve walks up the podium and begins to tell her story to the group, her voice echoing off the gymnasium walls:

I’ve never spoken at a fairly decent sized meeting before. So I guess I’ll just start. I had a really great childhood, like the picket fence, great parents and a great family in general. There was no trauma, no addiction in my immediate family, nothing specific to point the finger at—that’s why she got addicted to dope, there’s nothing like that. Yeah, I had a really great upbringing. My father passed away when I was young but my mother was always there for me. I did well into school, I got into a great college, went to school for nursing, then I got prescribed pain medication for a back injury I’d had since I was 16-year-old. I was very naïve like a lot of

people are. I took it as I was prescribed... [as if] that was going to be sufficient in terms of being vigilant and responsible with it. My doctor was extremely irresponsible and one day just took me off of it. And I had sort of messed around—my prescription was percs—had bought pills on the street, and then my doctor just took me off of it and my mother is an RN, and I saw horror on her face like, you're in full withdrawal right now.

And what I remember the most is feeling she was like disgusted with me, like I had done something wrong, like I had brought this on myself somehow. It was a really fast progression from taking my prescription and buying shit on the streets to figuring out heroin was cheaper. And I was always the person that was very big on —you know, I went to school, I have a job, I run a non-profit organization, very holier than thou, condescending, I'll never touch it, I'll never get to that—it was always why I was better than that, not looking at it the right way, not realizing that that could happen to me... I was always really scared of needles and I guess that I thought that because I was scared of needles and getting a shot at the doctor that I [never] could possibly be an IV drug addict, and one day it seemed like a really fricking good idea to shove a needle in my arm.

Eve's story is not atypical. She is white (Jewish), thirty-years-old and hails from the well-off (predominantly white) suburbs south of Boston. Her house sits on a cul-de-sac in a planned suburb notable for its manicured, rolling lawns and solid brick houses with two- or even three-car garages. At the time of her heroin use, she did not conform to the stereotyped habitus of a heroin addict; in fact, she was obese. She traces the beginning of her drug use to mismanagement by a physician over pain initially caused by a combination of a bulging disk and scoliosis. Diagnosed by MRI and physical exams, Eve was given prescriptions for various kinds of pain medications, including tramadol (a medication that works weakly at the opioid receptors, as well as affecting two other brain chemicals, serotonin and norepinephrine) and then Vicodin (hydrocodone/acetaminophen). She was prescribed these medications under the supervision of a local pain-neurological clinic.

This was back in 1999, in the early years of the increasing availability of prescription pain pills. Eve noticed that when she took the tramadol, she felt more energy, which was perfect for assisting her at her job as a nanny. She started “eating them like candy” and both the

tramadol and the vicodin were effective at taking away her back pain. She recounts how they gave her so many pills that it didn't matter if she took more than prescribed—"they gave me enough that it didn't matter." When I asked her if taking prescription narcotics indefinitely was her treatment plan, Eve admits that the physicians did not intend this: "The doctor at the pain clinic was onto it, we can't just keep throwing pills at [you], we're going to schedule you for what they call an epidural. They were going to shoot medicine into the space in my back, and I had that procedure booked a couple of times and kept cancelling it, and refilling my prescription in the meantime, and around that time we [she and her boyfriend] started doing heavier stuff." Upon prompting, she reveals that she never had a real conversation with a physician about the pros and cons of having an epidural steroid injection, but that the pain clinic would keep sending "endless" refills of vicodin and tramadol. Eve elaborated that, "I would talk my way around [doctors]... I'm on my feet all day at work, chasing toddlers around. And yeah, they would just keep giving them to me."

So Eve would take more of her vicodin and tramadol than she was prescribed, but she was mainly interested in trading them or selling them for oxycodone that she sniffed. She would get about thirty vicodin pills a month, and sell them for approximately \$7 a pill. The tramadol were less desirable; she could sell them for \$2 a pill, but usually she would take them herself if she felt "sick" (in withdrawal). Eve was concerned about taking too many vicodin because "you don't want to take too much of it because it has the acetaminophen in it, so I'd still take too much, but you know, less."

Eve was really interested in sniffing oxycodone and the steady supply of vicodins that she received from a physician allowed her a bargaining tool into obtaining them. She and her boyfriend were both working; she was working full-time as a nanny for a physician and an

academic and her boyfriend was working full-time as a computer engineer. They owned a house in the North Shore and she was running a dog rescue organization. They were snorting oxycodone at night and in the morning together before and after work. Surprisingly, Eve and her boyfriend Thomas were able to maintain this for five years, a relatively long time, before moving on to heroin.⁸⁰ At one point, they bought benzodiazepines online without a prescription. She tells me how it worked:

I was prescribed Klonopin, not that many of them, but [Thomas] liked them. So we found this online pharmacy that you could order without a prescription, Xanax, Klonopin. And the guy emailed me one day after we had placed a few orders and he's like I have stuff that's not listed on the website: OxyContin, and they shipped it. And it was pretty damn cheap in terms of OxyContin... We'd order 20s [20 mg tablets] through there, they didn't have anything stronger. And we'd order maybe twenty of them at a time? I think maybe the 20s were 10 dollars [each]. And we only did that for a little while, because it was going through the mail, and one time one of the packages got seized.

Eve, like many other people in the beginning throes of a narcotic addiction, would try to regulate and time her use so that she could maintain functionality at work: "I was good about timing it so I wasn't high at work but I wasn't sick at work... I would try to do not enough to be high, save that for after work. Just do enough [in the morning] that I'm not sick." Eve and Thomas gradually progressed to heroin when their dealer had no oxycodone available, and they moved rapidly from sniffing heroin to shooting it. They started selling all their possession in the house, and Thomas lost his job and Eve quit hers because she was too strongly affected by the heroin to perform a job running after children. They would wait around all week for Thomas' unemployment check to come in. It became impossible for them to go on trips with Thomas' wealthy parents because they would have been separated from their heroin supply and would have been dopesick; Eve laments that they begged off going on family vacations to the French Riviera wine country and Egypt.

⁸⁰ I suspect that Eve was able to maintain her opioid addiction this long—for five years—before moving to heroin because she and her boyfriend were able to perform pain scripts successfully enough to obtain prescription opioids from physicians. This stands in contrast to women with lower cultural, educational and social capital who often move quickly to heroin.

Eve's story is not atypical example of a common white, upper-middle class pathway into opiate addiction. It illustrates the centrality of pain and the treatment of pain as one pathway into addiction. Heroin addicts and physicians alike proclaim that Eve's story is so classic that it almost seems like a stereotype.

It is impossible to understand addiction without delving into painful worlds and bodies in pain. Pain is deeply imbricated within our human experience (Good, Brodwin, Good, & Kleinman 1992) and it is both a causal factor in drug addiction and alleviating it is a commonly cited reason for ongoing drug use. The question of how to best ameliorate or treat acute and chronic psychic and physical pain is as old as human history. And the experience of pain and its treatment are dogged by moralizing. Jean Jackson writes that because we all have experienced pain before, "The suffer needs to stop being childish, self-indulgent, and weak; rather, he should "pull himself together." If female, she should seek psychological counseling" (Jean Jackson 2011: N.P.). One's response to pain is a testament to one's internal character and resolve; John Locke once wrote, "If we were to take wholly away all Consciousness of our Actions and Sensations, especially of Pleasure and Pain, it will be hard to know wherein to place personal Identity" (Davenport-Hines 2002: 41).

Opiates are simply one of the best, most effective, ways we know how to deal with pain. They are a class of substances, produced naturally by the body or manufactured synthetically or found in nature, that confront and assuage pains of all varieties by binding to the μ -receptors in the brain. These receptors, when stimulated, inhibit the release of dopamine from other neurons in the brain (Swift and Lewis 2008). When morphine or heroin or some other type of opiate comes into the blood and subsequently to the brain, the drug sits on the receptor, causing disinhibition of the dopamine reward neurons (an increased release of dopamine that triggers the

reward pathways in the brain). Clinical signs of opiate use are a subjective feeling of euphoria followed by sedation.

As historians of medicine have noted, the treatment of acute or chronic pain with opiates in the United States dates back to the use of morphine for soldiers in the Civil War (Acker 2001; Courtwright 2001). Opiates were heralded as a miracle drug, a cure-all, a panacea for all pain. For women especially, opiates like morphine and laudanum were touted as particularly suitable for the physiological conditions of women such as childbirth and menstruation. Women's physiology was seen as essentially painful. Addiction was an unintended but necessary consequence of treating pain; it was iatrogenesis itself, or harm/injury that was a by-product of "medical necessity." It was not necessarily pejorative; a lifetime of physical dependence on the substance was seen as the trade-off for necessary pain relief.

Addiction amongst "medical users" was seen as legitimate, even morally acceptable, legitimized by the medical profession's backing and growing sphere of influence. The use of "medical" types of opiates, such as laudanum and morphine, became increasingly opposed to "non-medical opiate" use, or heroin, that was seen as a product of the street.⁸¹ Physicians were always a fairly large source of opiates and consequently addiction; as historian David Musto writes, "Oliver Wendell Holmes, Sr., in an address delivered just before the Civil War, blamed its prevalence on the ignorance of physicians. Holmes, then dean of Harvard Medical School, reported that in the western United States 'the constant prescription of opiates by certain physicians...has rendered the habitual use of that drug in that region very prevalent' " (1999: 4).

⁸¹ Heroin (diacetylmorphine), originally discovered in 1874 by London chemist C.R. Alder Wright, but synthesized and manufactured two decades later by a German Bayer chemist, Felix Hoffmann, in 1897, was marketed as an anti-tussive medication but was also thought to be a non-addicting, "safe" analgesic alternative to opium and morphine. As Nathan Eddy, the executive secretary of the Committee on Drug Addiction and Narcotics, recalled, "The introduction of heroin, can, I think, be fairly pinpointed as the first of the claims for a nonaddictive potent analgesic"; others at the time of heroin's introduction were also proposing that "during the withdrawal treatment of addicts to morphine, heroin was a safe temporary substitute" (Eddy 1963:673).

Clinics run by liberal physicians that maintained people who had accidentally or otherwise become “addicted” were heavily policed by Federal Bureau of Narcotics agents and eventually shut down (Musto 1999). The doctors who supplied narcotics were accused of being “dope doctors” by the government agents, under the direction of anti-narcotic evangelist Harry Anslinger, the long-time director of the Federal Bureau of Narcotics. Anslinger set the tone for three decades for government intervention in drugs of all kinds, including opiates; he encouraged moralizing evangelism in highly racialized, gendered, xenophobic and class-based forms to urge the public to call for further regulation and policing of drugs. Importantly, this so-called licit/illicit distinction continues to be relevant in modern debates about drug use; it has essentially become a means of dividing, controlling and surveilling a population of drug-takers.

An Industry of Pain Relief

“I had just given birth. My doctor gave me percs [percocet] and I just remember taking them and being high and cleaning... I took four or five at a time. I was prescribed them for pain related to the [vaginal] delivery.” - Lisa, interview at Suffolk House of Correction, Boston, MA

Kim: So you guys did the oxys for years?

Jennifer O: Yeah.

KS: They were the 80s?

Jennifer O: Oxy 80s.

Kim: What was your typical day? How many would you need to use?

Jennifer O: Seven to ten.

Kim: Seven to ten 80s? Um... between the two of you?

Jennifer O: No that would be each. We'd go through like 20 a day.

Kim: And you guys weren't paying for them... the ones he got [to sell]?

Jennifer O: Yeah.

In 1995, the Food and Drug Administration approved extended-release oxycodone (OxyContin) in 80-milligram tablets for the treatment of cancer pain or patients with moderate to severe chronic non-cancer pain. It was approved, in accordance with the federal Controlled

Substances Act, as a Schedule II drug, meaning that it was thought to have “high potential for abuse” (Courtwright 2004). Known on the street at OC80s, and generally sold on the street for \$1/mg, this was an extended-release formulation pill that contained a quantity of opiate medication that was bio-equivalent to taking immediate-release oxycodone four times a day. Produced by Purdue Pharma, a company based in Stamford, Connecticut, OxyContin was branded by the company as “reduced-risk” and less liable for abuse than fast-acting narcotics such as Percocet. The active biochemical compound, oxycodone, was not a “new drug” by any means, having been first isolated and discovered in 1916 in Germany (Sneader 2005), and oxycodone was widely available as a generic medication at the time of the approval of Purdue’s new formulation.

What differentiated Purdue from its generic competitors in the oxycodone market was the scale of marketing and the extent of its marketing budget. Purdue Pharma was the pain division of a pharmaceutical company originally bought by the famous Sackler brothers (perhaps better known for art collecting and museum fame). Arthur Sackler, one of the innovators of targeted pharmaceutical marketing, helped fund his brothers Mortimer and Raymond’s purchase of Purdue Frederick pharmaceutical company in 1952 (Meier 2003). Arthur was credited with honing specific pharmaceutical advertising techniques from years working at an advertising agency; according to the Medical Advertising Hall of Fame, “Arthur’s scientific knowledge and ability to expand the uses for Valium helped turn it into the first \$100 million drug ever” (Eban 2011). He was an innovator of the now ubiquitous techniques of wooing physicians with dinners and paying them exorbitant fees for speaking about the benefits of the drug; these practices are now a common space for ethical and ethnographic inquiry in the dissemination of medical and scientific knowledge (Petryna 2009; Lakoff 2006).

OxyContin was aggressively marketed and specifically targeted to both primary care physicians and prescribers who had already been identified as “the most frequent prescribers of opiates...in some cases, the least discriminate” (Van Zee 2009: 222). The commercial success of the pill was the product of conscientious and unprecedented marketing efforts in the history of pain pharmaceuticals as well as cultural shifts in the treatment and management of pain (Resnick and Rehm 2001).⁸² Purdue Pharma stepped in with OxyContin, playing on these shifting cultural and biomedical attitudes. They sponsored lectures to primary care doctors, who might have been less educated about the risks of prescribing opioids, on how to deal with chronic pain in a primary care setting. Purdue saw immediate pay-off for their efforts; narcotic pills were widely available, flooding cities, suburbs and rural towns alike. It was not just OxyContin but opiates as a class of medication: Wall Street analysts Cowen & Co reported that in 2010, 254 million prescriptions for opioids were filled in the United States, enough for every American to be medicated around the clock with a narcotic (Eban 2011). A study conducted by substance use researcher Thomas McLellan at the University of Pennsylvania in 2011 showed that opiates were the most widely prescribed class of medications in the country (Volkow and McLellan 2011).

There were also important cultural reasons beyond pharmaceutical gamesmanship that contributed to the vast popularity of these medications on the street. Over the past fifty years, people had become acclimated to taking pills for a variety of reasons: to enhance physiological processes (to perform better in exercise or to improve attention, decrease anxiety, improve sleep)

⁸² See Ben Rich’s “A Legacy of Silence: Bioethics and the Culture of Pain,” *Journal of Medical Humanities* 1997 (18): 233-259 for a detailed cultural analysis of shifting biomedical orientations towards the treatment of pain (Rich 1997). Among healthcare providers, there was an increasing realization of the under-treatment of pain, particularly regarding palliative care and end-of-life situations and chronic and infectious diseases (Cleeland 1998; Breitbart et al. 1996). There was also a simultaneous and concerted effort by pharmaceutical companies with products on the analgesic market (like Jansen and Purdue) to create materials for a popular/general audience about the under-treatment of pain and its consequences. In 1993, Purdue created a resource group called “Partners Against Pain” – “to help patients, caregivers, and healthcare professionals advance standards of pain care and alleviate unnecessary suffering through education and advocacy” (McCormick et al. 2009: S44).

and also as solutions for pathophysiological problems of the mind and the body (Dumit 2007; Jenkins 2012). In American culture, people became comfortable taking pills of all kinds from very early ages, including, but not limited to, antibiotics, vitamins and birth control. It is not uncommon to see others take pills at breakfast, lunch or dinner, making the pill a largely non-stigmatized way to consume medicines. The widespread nature of pill-taking and its acceptability made OxyContin and later suboxones attractive, more palatable to people who might have been otherwise averse to street drugs and who might not have known how to prepare them.

Oxycontin generated \$3.1 billion in total revenue in 2010 for Purdue Pharma; opioids as a class of medication proved to be a big business over time with careful planning and marketing.

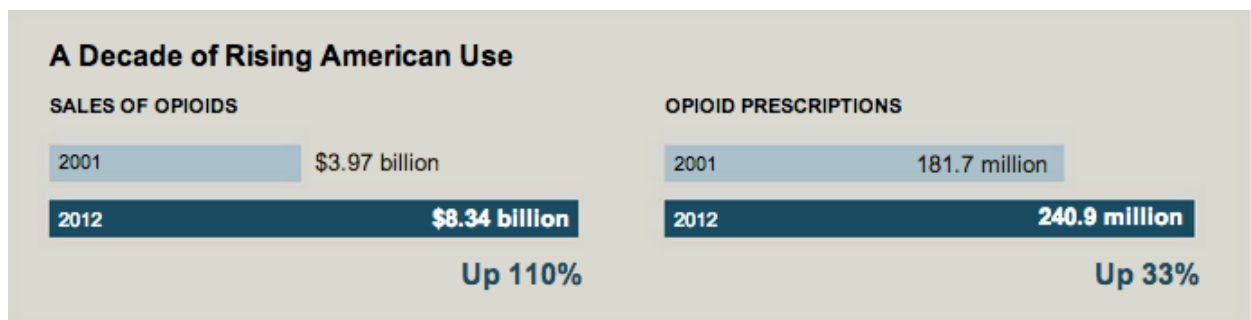


Figure 5.1: Sales of opioids and use of opioid prescriptions (Barry Meier and Bill Marsh, “The Soaring Cost of the Opioid Economy,” *The New York Times*, June 22, 2013)

Their products were widely available due to aggressive marketing and specific corporate techniques utilized by most pharmaceutical companies. Physician Art Van Zee noted that “among new initiates to illicit drug use in 2005, a total of 2.1 million reported prescription opioids as the first drug they had tried, more than for marijuana and almost equal to the number of new cigarette smokers (2.3 million)” (2009: 244). The number of prescription opioid-related overdose deaths dwarfed those of heroin and cocaine combined (CDC MMWR 2011). The reach

of the pills, particularly into white households across the class spectrum, was of unprecedented magnitude.

In Massachusetts, as in many other regions across the country, prescription pain medications were written in epidemic proportions. The state legislature established the Massachusetts OxyContin and Heroin Commission under the Acts of 2008 “to investigate and study the impact of the OxyContin and heroin epidemic on the state and municipal governments and recommend policy solutions to help stem the tide of this epidemic” (OxyContin and Heroin Commission Commonwealth of Massachusetts 2009). OxyContin was thought to be especially popular among white Bostonians: as epidemiologists of drug use trends reported, “Boston police, treatment providers, and outreach workers continued to report OxyContin as a major street drug of abuse, especially among young White residents” (Dooley and Clark 2002: 30). In fact, 18 of the 36 women in my study had started their heroin addictions with prescription opioids, specifically naming oxycodone or percocet. A woman’s age was almost exactly indicative of whether she had first started using prescription opiate pills or heroin (older women went straight to heroin almost uniformly).

The authors of the OxyContin commission, comprised of State Senators and Representatives as well as substance use experts across the state, compared the severity and devastation of this epidemic to the ongoing wars in Iraq and Afghanistan. They noted in their report that

addiction to the powerful painkiller, OxyContin, became evident almost immediately following FDA approval of the drug in 1995. In Massachusetts, OxyContin became so widely abused, that the addiction rate for the drug in Massachusetts increased by 950 percent over the last ten years. The problem also became clear from the immediate rise in opioid related hospitalizations in the Commonwealth. In 2002, Boston had the highest rate of OxyContin related emergency department visits in the country and in 2005, there were more than 18,000 opioid related emergency department hospitalizations and hospital stays (OxyContin and Heroin Commission Commonwealth of Massachusetts 2009: N.P) .

Individuals working in the medical and addictions field noted that people would report starting on opioid pills but would then eventually move to heroin, as was the case with Eve. There are several reasons for this: pills have a shorter half-life (they don't last as long in the body as heroin); the pills are more expensive than heroin; and the high from heroin is stronger (more euphoric). So once someone obtained physiological dependence or tolerance to opiates, heroin would feel stronger. Cheaper, better, and lasts longer, plus arguably easier to procure: who wouldn't turn to heroin?

Purdue Pharmaceuticals downplayed the risk for addiction in their marketing efforts, while admitting to the fact that physiological dependence could occur. The Vice President for State and Government Affairs at Purdue, Alan Must, was quoted saying that “obviously, the idea that our business model is based on getting patients addicted and dependent is absurd,” although it is “not unusual for patients to become physically dependent” (Eban 2011). The distinction between physiological dependence, and abuse/addiction, is a fine one that traditionally has hinged on behavior and functionality. According to the psychiatric bible, the *Diagnostic and Statistical Manual-IV*, dependence on a substance is a physiological process (not taking the substance results in withdrawal symptoms). It also meant individuals gained tolerance to an ingested substance, so a patient might need a higher dose of a substance in order to achieve the desired effect. Abuse, on the other hand, reflected bad behaviors: that is, the “continued use despite persistent or recurrent social or interpersonal problems caused or exacerbated by the substance” or a general “failure to fulfill major role obligations at work, home or school” (American Psychiatric Association 2000). This distinction between dependence and abuse was erased in the latest version, the DSM-V, replacing it with the term “addictions and related disorder” given the

semantic confusion between the terms and also with the word “addiction” (O’Brien, Volkow, and Li 2006).

Art Van Zee, a physician working in a Virginia clinic that was plagued with new cases of OxyContin-related addiction, reported that “when OxyContin entered the market in 1996, the FDA approved its original label, which stated that iatrogenic addiction was “very rare” if opioids were legitimately used in the management of pain” (2009: 224). Purdue officials later faced charges of deceptive marketing strategies (“misbranding”), mail and wire fraud, along with a host of other felonies; three executives including the president and its chief legal counsel pled guilty to misdemeanor charges of misbranding the drug (Meier 2007). Internal documents from Purdue revealed that they knew that large quantities of oxycodone could be easily extracted from the pill for injection; they also knew that doctors would be concerned about the drug’s potential for addiction and yet still engaged in a campaign that said otherwise. Sidney Wolfe, of the health advocacy group Public Citizen, called the heads of the Purdue company “white-collar drug pushers” (Meier 2007).

As a result of the bad publicity, Purdue Pharma responded by creating a different version of OxyContin (known on the street as OPs). Released in 2010, they were touted as “tamper-proof” and “tamper-resistant.” Made of different binders, they would become gelatinous if crushed. The price of OxyContin on the street dropped 20 to 30 percent (Muhuri, Gfroerer, and Davies 2013), leading experts to think that OPs were undesirable and that the “tamper-proof formulation” was working. One of the unintended consequences was that the individuals who had already become accustomed to and physically dependent upon OxyContin soon moved to heroin. Several of the women I met in prison told me the same story; as Mae recalls, “Once the 80s disappeared, they

moved right into heroin, and we couldn't find anything else so we told them to pick us up a bag [of heroin] too.”

Purdue profited from their altered compounding: just when the patent on the original OxyContin had expired and would have become generic, the Food and Drug Administration voted in April 2013 to prohibit the manufacture of generic OxyContin (Meier 2013).

Pharmaceuticals and Crime

The pharmaceutical companies pleaded ignorance and lack of complicity for the resulting epidemics of addiction taking place in waves across the country; they could not be blamed for what physicians did, or what patients did with pills if they were not “taking them as prescribed.” Yet they were forced by the government to address the (possibly) unintended consequences of the social lives of their products (Appadurai 1986); as a result, Purdue Pharma began to fund a wide variety of programs aimed at controlling the OxyContin-related crimes (home burglaries, robberies of pharmacies, street violence, etc). The resulting enmeshment of pharmaceutical companies in crime and criminal justice-related activities was remarkable.

Purdue focused these efforts on areas of “diversion” and “risk management,” publicizing a variety of programs they were funding. The government required pharmaceutical companies including Purdue to develop Risk Evaluation Mitigation Strategies (REMS) and to spend money on policing the misuse of the drug. Purdue sponsored the development of a program called the Researched Abuse, Diversion and Addiction-Related Surveillance (RADARS) System that would track prevalence and diversion of prescription opioid medications over time and according to zip codes. They began to operate a website called RxPatrol (Rx Pattern Analysis Tracking Robberies & Other Losses), containing police reports of drug-related crimes, and offer a \$2500 CrimeStoppers reward for the resolution of “incidents” that occur in pharmacies. Primarily

meant to deal “pharmacy crime” related to oxycodone addiction, “Purdue Pharma L.P. has conceived, developed and funded an information clearinghouse for data related to pharmacy robberies, burglaries and theft that involve the loss of controlled substances.” It is, according to their website, “administered by individuals with former law enforcement experience from Purdue Pharma’s Corporate Security Department” (the accompanying photograph shows retired individuals from the NYPD and Connecticut Police departments). According to Eban, “Purdue has even given thousands of height charts to pharmacies to help witnesses guess the height of robbers” (2011).

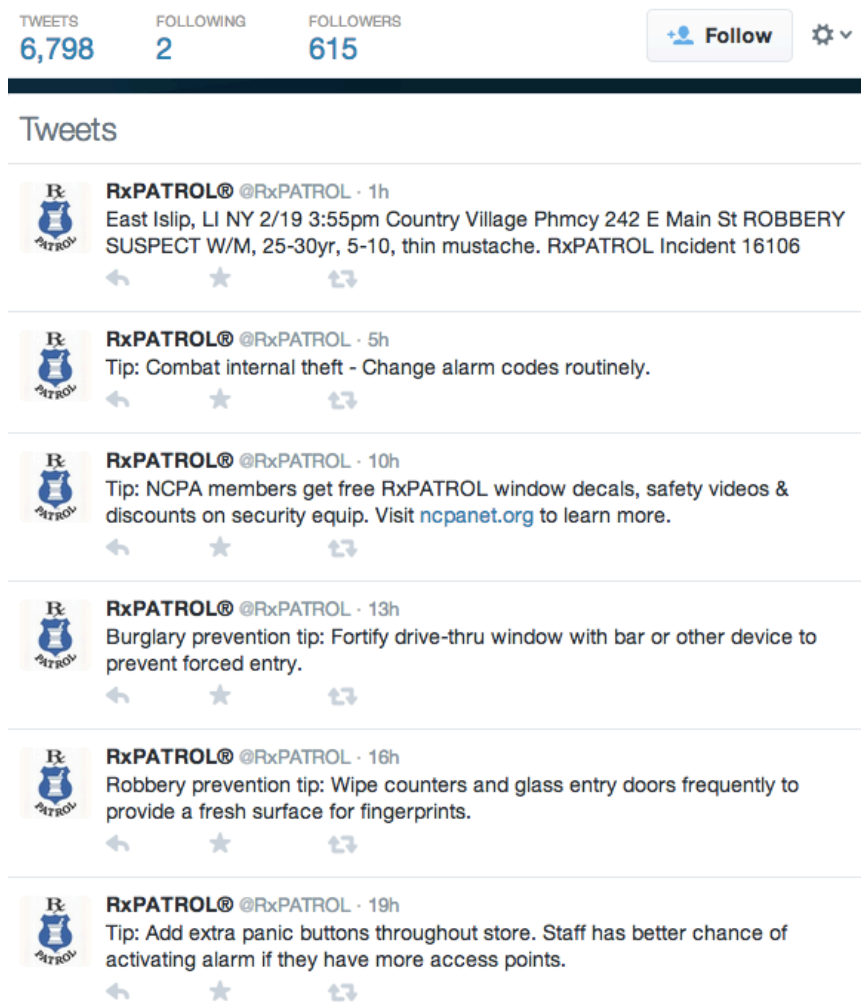


Figure 5.2: Tweets from the RxPATROL’s Twitter feed (available at <https://twitter.com/rxpatrol>)

The level of imbrication of pharmaceutical companies in crime control pursuits was vast. Purdue proceeded with to heavily publicize their efforts and programs even though the Centers for Disease Control (2013) noted that “very few come from pharmacy theft.” According to Purdue, their work with CrimeStoppers “resulted in 91 arrests. This *array of surveillance and intervention strategies is unprecedented* among companies marketing CII opioids” (McCormick et al. 2009; emphasis added). They also provided grants and training to law enforcement programs to deal with drug abuse (Eban 2011; McCormick et al. 2009: S45).

Perhaps this is just the nature of doing business in the realm of narcotics, pain and addiction. But Purdue’s actions reveal the new and insidious reach of pharmaceutical involvement in shaping and responding to policing and crime, blurring and altering the traditional orientations towards crime and public safety (see Garriott’s 2011 treatise on *narcopolitics* where he shows how policing in rural West Virginia is fundamentally altered by drug crimes). Purdue stepped into the criminal justice arena and played off existing dichotomies of good versus bad (licit/illicit) drug use; they depicted themselves as the good guys, working to ensure order and public safety, while the drug-addled, OxyContin-addicted pharmacy robbers were the bad guys. The pharmaceutical companies were going to do their best to stop these criminals, even though the Centers for Disease Control noted that pharmacy crime was responsible for only a small percentage point of “pharmaceutical leakage” (Lovell 2006) to the street. Purdue sought to seize control of public relations and to mold a fresh public perception as a responsible corporate actor.

The notion of corporations manufacturing products with the potential for both harm and pleasure is perhaps best chronicled by the historian of medicine, Allan Brandt. Brandt’s carefully researched work documented the role of tobacco companies and their forays into clinical science

as well as politics and legislation. The use of cigarettes was promoted by tobacco companies in accordance with shifting cultural and scientific attitudes towards their products: they were branded as a choice, a pleasure, an act of volition and even defiance, in the face of health risks that began to emerge. Yet “to hold the industry responsible for such individual failings seemed to violate the core American values of individual agency and responsibility” (Brandt 2009: 5). Who was responsible for the ills and harms that smokers suffered over the years? Similarly, who was responsible for the epidemic of prescription narcotic addiction sweeping the country if individuals chose to use, abuse or misuse these products?

Peter Benson and Stuart Kirsch, in their article “Corporate Oxymorons,” write that corporations “often pair a desirable cover term such as safe or sustainable with a description of their product, for example cigarettes or mining” (2009:45). This is characteristic of the pharmaceutical pain industry. As Benson and Kirsch argue, we must both recognize and indict pharmaceutical companies for their role in doing significant practical damage through clever semiotic work: “Across multiple settings, multinational corporations have strategically turned to a language of social responsibility to legitimize corporate activities with negative human and environmental consequences. They use idioms of ethics, health, environmentalist, and corporate responsibility to conceal the contradictions of capitalism and promote business as usual” (Benson and Kirsch 2009: 45-46).

The pharmaceutical companies specializing in the analgesic market are doing just this, claiming to make safer, better products, while 100 people continue to die every day from drug overdoses; since 1999, prescription drugs are responsible for most of the increase in these deaths (Centers for Disease Control 2011). The very same companies like Purdue that were part of the widespread “prescription painkiller epidemic” have woven themselves intricately and tightly into

the solutions for the very same problem, gaining brand-name exclusivity on the new “tamper resistant” formulations of OxyContin and keeping the generic companies at bay.

The Booming Business of Addiction Therapeutics: The Case of Reckitt-Benckiser

Other pharmaceutical companies saw promise in the treatment of opiate addiction, partly in response to the widespread (over) use of prescription pain medication. They saw a lucrative niche market in maintenance treatment. As Penn professors John Kimberly and Thomas McLellan wrote in an article on the substance abuse treatment industry, “Pharmaceutical companies that, not long ago, refused to allow the use of even their discarded medications for clinical research in addiction now invest hundreds of millions of dollars in the marketing and sales of approved addiction medications” (2006: 216). Does this say something about the changing cultural attitudes towards addiction—that pharmaceutical companies are no longer afraid of being branded as making drugs for drug addicts—or does it rather speak to the enormous profits to be had?

The re-branding of addiction as a chronic, relapsing and remitting brain disease by the National Institutes on Drug Abuse in the 1990s, as well as the increasingly large numbers of opiate-addicted patients, laid the groundwork for pharmaceutical companies to become further invested in the treatment of opiate addiction (Leshner 1997; Leshner 1999; Koob and Volkow 2010; Goldstein and Volkow 2002; Vrecko 2010). The pharmaceutical industry was well aware of the implications that such an epistemological shift could bring: chronic diseases necessitate lifelong medical maintenance and constant vigilance, often with “drugs for life” (Dumit 2012). Advocates of the lifetime opiate maintenance model—primarily regarding methadone—argued that it was parallel to diabetics needing their insulin (Quenqua 2011).

The pharmaceutical division of a British multinational corporation, Reckitt Benckiser, eventually reaped significant profits (\$1.3 billion in total revenue in the US in 2011) off an opiate maintenance medication called suboxone (buprenorphine-naloxone). Yet Reckitt was not always so keen on getting into the addiction business, as Nancy Campbell and Anne Lovell have shown recently (Campbell and Lovell 2012). Buprenorphine had already been approved as an analgesic in injectable and sublingual tablet forms in twenty-six countries. It was increasingly being used “off-label” for the treatment of opiate addiction, as Lovell (2006) noted was the case in France. Campbell and Lovell describe Reckitt’s initial reluctance to re-brand the drug as one specifically for addiction: “The company’s reluctance to enter the addiction therapeutics arena reflected a more general attitude among pharmaceutical companies that analgesic might, as Bigelow put it, be ‘tainted’ in the eyes of prescribers and pain patients if also used for addiction” (2012: 134).

Buprenorphine is unique from the other approved opiate maintenance counterpart, methadone, in several key ways. First, it is a partial agonist at the *mu* opiate receptor in the brain, not a full agonist like methadone or heroin. This means it is relatively safer than methadone (one-third of prescription overdose deaths involve methadone), with less potential for respiratory depression and overdose (CDC 2012). Second, Reckitt manufactured buprenorphine in combination with a full antagonist naltrexone and marketed the combination as suboxone (the buprenorphine only drug is called subutex). Combining buprenorphine with naltrexone was meant to guard against people “abusing” the medication by crushing up the tablet and injecting it, since the naltrexone would become active if injected, creating unpleasant withdrawal symptoms in opioid-tolerant patients (although people came to realize you could still snort it and swallow it to ‘get high’).

Eventually, Reckitt brought subutex and suboxone to market with part of the costs of development absorbed by NIDA “to ease the burden to Reckitts” (Campbell and Lovell 2012: 135). They note that Reckitt had also obtained “orphan drug status” using the Cost Recovery principle “that the company risked not recuperating what it invested” given relatively high manufacturing costs, even though the size of the target market was greater than the 200,000 potential patients for so-called “orphan” drugs. This status resulted in seven years of patent exclusivity. The Drug Abuse Treatment Act passed in 2000 classified suboxone as a Schedule III drug that could be prescribed in an outpatient physician’s office. Getting this schedule was critical for widespread distribution of suboxone and Reckitt Benckiser lobbied the government aggressively to ensure that it was not deemed a schedule II drug (more liable for abuse; examples of schedule II drugs include morphine, oxycodone, medical cocaine).

Suboxone quickly became a blockbuster drug. Private physicians could prescribe it for patients at weekly or even monthly intervals, as opposed to the methadone clinic’s daily administration, semi-public dispensaries and intense stigma. Providers could not keep up with the demand; the maximum patient limit for providers was increased from 30 to 100 patients in 2006. There continue to be ongoing lobbies for nurse practitioners and physician assistants to be able to prescribe it to help address the demand for it, especially since these providers are already capable of prescribing even stronger drugs like methadone and oxycodone (not surprisingly, their efforts are supported by Reckitt Benckiser pharmaceutical reps).

Reckitt Benckiser girded themselves for the expiration of their exclusivity rights to the suboxone tablet in 2009 by preparing a new formulation of suboxone. They submitted a New Drug Application to the FDA for a sublingual film version of suboxone in October of 2008 (it was approved in August 2010, with patent exclusivity until 2023). Reckitt made it clear to their

shareholders in their 2011 annual report that the company could lose “up to 80% of the revenue and profit of the Suboxone tablet business in the US, following the launch of generic competitors... However, the Group expects that the Suboxone film will help to mitigate the impact” (Reckitt Benckiser 2011).

In September 2012, Reckitt Benckiser announced in a press release that they were voluntarily withdrawing the tablet formulation of suboxone off the market given the results of “specially commissioned data” that they had received from the U.S. Poison Control Centers indicating higher rates of pediatric overdose on the tablet formulation than the film version. As Reckitt-Benckiser wrote, “This is the first report provided to the company with conclusive outcomes since a preliminary review in early 2012 that showed a noticeable numerical trend but did not provide enough data points to make a statistical analysis.” They would take the tablet form off the market in the next six months in order to “protect public health and safety” (Reckitt Benckiser 2012).

Ed Silverman, a writer for Forbes.com, noted that Reckitt had been manipulating the cost of the tablet to encourage insurers to switch patients over to the film (Silverman 2013). According to his analysis, Reckitt raised the price of the bottle of 30 tablets from \$140.00 to \$161.70 for the 2mg dose and from \$252.00 and \$289.80 for the 8 mg dose, while the film version cost \$117.85 for 30 2mg films and \$211.15 for the 8mg version. They also offered a \$45 a month subsidy (Bloomberg reported on it as a “Coke-style coupon”) for a patient’s typical \$50 co-pay for the film (Fletcher 2011). Within six months of the introduction of the film, 40% of patients had been switched over to this new formulation, and by the end of 2012, it was 64%.

Hours after announcing their plan to take the tablets off the market, Reckitt announced in a press release that they had filed a “citizen’s petition” urging the FDA to “require all

manufacturers of buprenorphine-containing products for the treatment of opioid dependence to implement national public health safeguards involving pediatric exposure educational campaigns and child resistant, unit-dosed packaging to reduce the risk of pediatric exposure.” They asked the FDA to refuse to approve any new drug applications for generic suboxone tablets.

Several generic companies filed suit against Reckitt. In one of them filed in December 2012, the generic drug manufacturer, Burlington Drug Company, alleged the “unlawful exclusion of competition from the market” in violation of the 1984 Hatch-Waxman Act, citing a “product hopping” scheme (Burlington Drug Company 2012). They argued that the film version “offers no additional benefit to consumers but has effectively prevented generic competition.” Furthermore, to counteract claims of the high risk of pediatric overdose if a child could access a bottle of tablets, the lawsuit pointed out that Reckitt did not offer “Suboxone Tablets in unit-dose packaging in the United States as it does with Suboxone Film, even though Reckitt offers the tablet product in unit-dose packaging in other countries.” They claimed that a generic would have been on the market almost a year earlier if not for Reckitt’s assorted anti-competitive actions.

Reckitt, of course, is not alone in its efforts to maintain market share. It is extremely common for pharmaceutical companies to utilize minor innovations, such as slightly altering the drug delivery mechanism, the method of administration, etc., in order to extend the life of their brand-name drugs or obtain new patents. For example, the pharmaceutical companies behind Oxycontin and Opana, Purdue and Endo, have released versions of their long-acting narcotics that they claim are more resistant to being crushed and melted; they sought to prevent generic versions of their long acting narcotic pills that do not have similar “tamper-resistant designs”

(Thomas and Meier 2013; Fudala and Johnson 2006). Like Reckitt, they are in the business of addiction and can therefore explicitly market these maneuvers under the aegis of “public health.”

In March 2013, the FDA issued its response to Reckitt’s “citizen’s petition” by actually approving two generic versions of suboxone to Amneal and Actavis pharmaceuticals (Woodcock 2013). The FDA ruling noted that “although child resistant unit-dose packaging could provide additional deterrence to accidental pediatric exposure, many products which are potentially harmful to children are distributed without unit-dose packaging” (for example, there are tens of thousands of cases of pediatric poisoning of acetaminophen every year to the Poison Control Centers). The FDA furthermore noted that Reckitt had not withdrawn the drug from the market even though they had hyped such significant safety risks to children.

The FDA called out Reckitt for its various schemes, referring the matter to the Federal Trade Commission “to investigate and address anticompetitive business practices.” As Janet Woodcock, the Director of the FDA Center for Drug Evaluation and Research, wrote in the ruling, “The timing of Reckitt’s September 2012 announcement that it would discontinue marketing of the tablet product because of pediatric exposure issues, given its close alignment with the period in which generic competition for this product was expected to begin, cannot be ignored” (Woodcock 2012).

What does all this pharmaceutical maneuvering mean for patients and providers? From my fieldwork conducted in a suboxone clinic in Boston, I observed that it mostly led to confusion, lack of consistent access to medication, and loss of trust in the clinic. Most of the patients were covered by MassHealth (the public insurance option in the state), and MassHealth initially refused to cover the sublingual film version without prior authorization. Private insurance companies such as Neighborhood Health Plan and Blue Cross did approve them.

Those patients were switched to the film version and gradually MassHealth approved the film version for all suboxone prescriptions. When generic suboxone tablets were announced, MassHealth rescinded this and said that everyone would take the generic suboxone tablet when it became available. The patients were the ones left in the lurch with disruptions in coverage and access given the confusion by the pharmaceutical companies, insurance companies, and the state.

Reckitt continues to look for greener pastures, including trying to develop an injectable, long-acting depot version of buprenorphine (they also hired a veteran of SAMSHA to help them navigate the federal regulations). Yet their story is testament to the new pharmaceutical economies built up around managing the poor and the sick. It also speaks to the booming business of addiction treatment and the increasingly larger part that Big Pharma wants to play in shaping and legislating notions of risk, safety, public health and even criminality. Would this situation have been possible if Reckitt had not been able to play on the unique, cultural and moral attitudes that our country has towards drug addiction (for example, playing on the unique fears of children overdosing on drugs meant only for drug addicts)?

Vivitrol: Getting a Shot at the Opiate Addiction Market

Alkermes Pharmaceuticals is a local Boston-area company based out of Waltham, Massachusetts. Known for producing antipsychotic medications such as Risperdol and Risperdol Contra (the long-acting injectable form), Alkermes has recently staked a claim in the growing addiction market. The product they are heavily promoting in the Massachusetts area as well as nationally is branded as vivitrol, a long-acting injectable form of an old generic medication, naltrexone. Alkermes gained approval from the Food and Drug Administration for vivitrol

(naltrexone for extended-release injectable suspension) in 2006 for the treatment of alcohol dependence; they gained approval for the treatment of opiate addiction in 2008. Naltrexone belongs to a class of medications called opioid antagonists (unlike suboxone and methadone, that are partial or full agonists at the mu receptor). Antagonists effectively sit on the receptor and compete with agonists that might want to bind. Because they are not agonists, there is no high or sense of euphoria (see glossy figure below from the vivitrol website). The website advertises that vivitrol is “an effective complement to psychosocial treatments”; it is not “a narcotic; pleasure producing; addictive; or associated with abuse” (vivitrol.com).

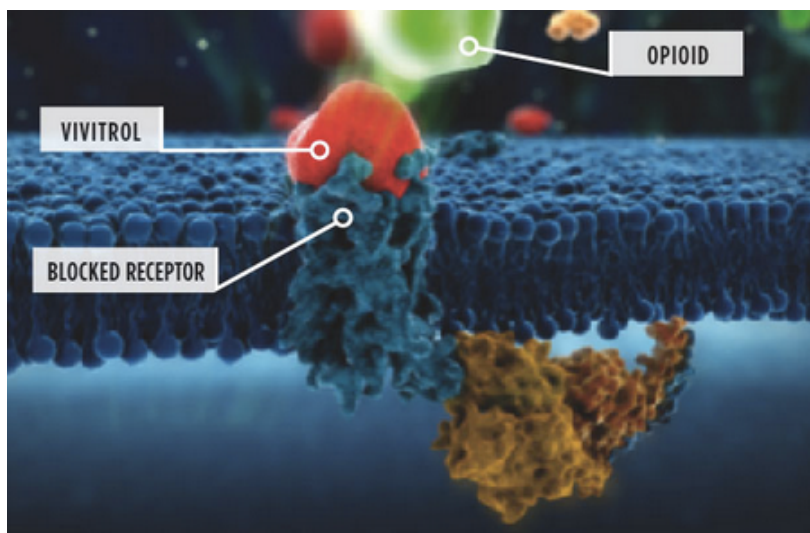


Figure 5.3: Brain chemistry diagram demonstrating how vivitrol works at mu receptor (vivitrol.com, produced by Alkermes Pharmaceuticals)

As the overly tan vivitrol representative told us one day at the public health, state-run hospital where we were having pharmaceutical-sponsored lunch and a presentation on this medication, “What we like to do at Alkermes is take pre-existing, gold standard of care and find a better way to deliver that medicine to the patient.” In fact, Alkermes did just this with Risperdol, drawing on the well-known clinical data that showed that patients who need

psychiatric medication often refused to take their pills. Yet while Alkermes held the patents on Risperdol and manufactured it, they had licensed it to Jansen Pharmaceuticals to market and sell. Vivitrol was the first medication that Alkermes held onto as its own. As the representative told us, “The most profitable way, and what we’re doing more now, is to take it, own it, commercialize it, and sell it.”

Alkermes won FDA approval based on a proof-of-effectiveness study conducted in Russia (it is also marketed by Johnson & Johnson in Russia for the treatment of alcohol dependence). The proof-of-effectiveness studies done in Russia reflects the new global pharmaceutical clinical trial marketplace in which pharmaceutical companies traverse uneven access to basic standards of care in medical treatment and a variety of opinions on participation in human subjects research (Petryna 2009). The study of 250 patients involved two randomly assigned groups: one to naltrexone or to placebo and all patients received 12 biweekly therapy sessions (Krupitsky et al. 2011). The endpoint was abstinence by urine test and self-report 5-24 weeks later. Of the 250 randomized to the groups, 59 out of the 126 of the naltrexone group did not complete the trial and 77 of the 124 assigned to placebo did not complete the trial. They found that total abstinence was reported in 36% of the patients that received naltrexone versus 23% that received placebo. That the trial was conducted in Russia was an issue the authors raised in the discussion: “Nevertheless, given the population and treatment system differences, generalizability of these results beyond Russia is a topic for further research” (Krupitsky et al. 2011: 1511).

The study had many critics and the FDA approval of the drug base largely on a small clinical trial worried many physicians: “Factors requiring scrutiny include paucity of efficacy data, adequacy of risk assessment (particularly of overdose risk in treatment dropouts), and the

questionable ethics of a placebo-controlled trial when an accepted standard of treatment exists” (Wolfe et al. 2011:1468). What was most egregious was that the drug was tested against placebo in Russia, given that opioid-maintenance medications are illegal there. They cited previous studies that showed that oral naltrexone was less effective in treating opioid dependence than buprenorphine, one of the standards of care for opioid dependence in the United States. It “raises the question of why investigators chose that country to test a drug for which US approval would be sought” (Wolfe et al. 2011: 1469).

Nora Volkow, the head of the NIDA, wrote upon its approval, “As a depot formulation, dosed monthly, vivitrol obviates the daily need for patients to motivate themselves to stick to a treatment regimen-a formidable task, especially in the face of multiple triggers of craving and relapse. The new option increase the pharmaceutical choices for treating drug addiction... NIDA is continuing to support research on vivitrol’s effectiveness in this country, including a focus on criminal justice involved populations transitioning back to the community” (Volkow 2010).

As Volkow alluded to, Alkermes was rapidly expanding and marketing vivitrol not only to private and public addiction treatment centers and hospitals, but even to individuals. I saw the company directly tabling to individuals, advertising vivitrol with glossy posters of the brain at Recovery Day at the Massachusetts State House during a lunch full of hundreds of people in recovery from drug addiction. Alkermes has also moved into the prisons and jails. One time, while browsing the literature available for women in the state prison facility, I found a Vivitrol pamphlet entitled “Seeking Treatment Options for Opioid Dependence?” in the New Horizons Re-Entry Center at MCI-Framingham.

Later, I spoke to the Alkermes representative as he was just “dropping by” to check in on how the vivitrol process getting off the ground at the hospital outpatient clinic. I asked him about

if he knew about the programs in various county jails where individuals could elect to receive a vivitrol shot before release in order to prevent the risk of relapse upon release. He told me that the company was involved in a pilot program with Barnstable County (Cape Cod), whereby, “They’re taking inmates that obviously volunteer and want to go on vivitrol, but it’s a little bit more than that, I think they write a letter saying why they want to go on vivitrol, what they expect to get out of it.” He tells me that inmates who volunteer receive the injection five days prior to release and the Barnstable sheriff’s office sets up the individual with a follow-up appointment with a drug treatment provider on the outside. The Barnstable County jail was interested in several outcomes: did the individual show up to the follow-up appointment, did they have clean urines and most importantly, was there decreased recidivism.

When I asked about recidivism, the rep told me, “Are they coming back? The only good thing we can say so far is it has nothing to do with drugs or alcohol... One of them was a woman and she slept at her boyfriend’s house, and I guess that broke the rules of probation, so she ended up back.” I learned that it was critically important for Alkermes to interact with a punitive penal culture and a culture that promoted abstinence as the best medicine for drug addiction.

Kim: It’s interesting in the jail to see their culture and their attitudes towards medication-assisted treatment.

Rep: We’re trying to change all that obviously.

It ultimately was about the “bottom line”; that is, the pharmaceutical companies needed to convince the government that starting naltrexone would decrease criminal justice involvement. The pharmaceutical company had several stakes in this: potentially, the jails could become bulk purchasers of vivitrol, and the initiation of vivitrol before release from prison could potentially mean many more months or even years of follow-up injections in the community. Researchers thought it could be life-saving; as the authors of the Lancet randomized controlled and double-

blind study wrote, “Antagonist pharmacotherapy is particular appropriate for patients who have achieved abstinence during inpatient treatment or incarceration and are at risk of relapse after discharge” (Krupitsky et al. 2011: 1507).

The rep told me that the program in Barnstable County was based on the pharmaceutical gift of medications to the prison: “We’re supplying the first injection at Barnstable [County Jail]. That’s a pilot program. I think what they’re going to look at, if it does save them money, then it would behoove them...” The rep told me that they have another person at Alkermes whose main responsibility is the “state/government affairs” and the “jail system.” She is eagerly trying to network throughout the state to set-up pilot programs between Alkermes and local jails.

Evidence of the efficacy of vivitrol is mixed. The shot costs \$1000 to insurance companies, while the generic oral equivalent costs pennies. Alkermes was banking that the price of adherence was worth it, since the treatment of addiction, much like psychosis and the case of long-acting Risperdal, was essentially all about adherence and patients not wanting to take their medication. It also appealed to criminal justice cultural orientations towards “abstinence,” albeit medication-assisted abstinence. The injection of vivitrol also was not “subject to illegal diversion” (Krupitsky et al. 2011: 1512), a topic of considerable “moral panic” and community concern.

I encountered several women in the prison system who felt favorably about vivitrol. One woman, Faith, had received vivitrol injections from a psychiatrist who was later arrested for defrauding the government.⁸³ She thought that the shot was “the best thing for me” because the

⁸³ Her doctor was Dr. Punyamurtula Kishore, the founder of Preventative Medicine Associates, which owned 29 addiction treatment facilities in Massachusetts. Each clinic prescribed both suboxone pills and vivitrol injections. He was charged with six counts of Medicaid fraud and an illegal kickback scheme associated with eight sober houses. The Massachusetts Attorney General Martha Coakley, announced that he was thought to have defrauded Medicaid/MassHealth of over \$3.8 million. He had bribed these sober houses to use his offices to test urine samples for \$100 to \$200 each. The owners of these sober houses were placed on the staff of Preventative Medicine Associates and Kishore’s associated charity, the National Library of Addictions (Schiavone 2011). It is important to

suboxone pills were “like playing a chess game”; she could exert agency over her medications almost as if she were playing a game—to take them now, later, or never. Also, “the suboxones I could sniff and get high. And I could sell them and make good money.”

The shot, on the other hand, makes it so “you can’t get high.” She did the shot for about six months while she was at an inpatient residential drug treatment program in New Bedford. She was “terrified” to use drugs while on it: “They told me if I used I could die. And I didn’t want to risk it. There’s no games. They said if you use on it you could die.” The important thing for Faith was there were “no side effects. If you do take it, you feel like you don’t take anything. You just get a shot and you feel fine. The shot was the best thing I’ve ever done in my life.”

For many people who use drugs, they aspire for abstinence even from maintenance medications like suboxone or methadone; the shot was a qualitatively different thing, as Faith explains: “I didn’t detox from anything, it wasn’t like a wrestling match with myself. I felt normal.” She decided to stop getting the injection when she decided she wanted to go out and get high. But she stills believes, “That shot saved my life for six months.”

While not making any claims about the effectiveness or ineffectiveness of the vivitrol, I do want to draw attention to the linkages that are being strengthened between prisons and pharmaceutical companies. There is a huge potential market for the treatment of drug addiction. Pharmaceutical companies are plying their trades in spaces of social abandonment. They are promising a substance that can stave off death. Indeed, for many in the medical community who work with incarcerated and formerly incarcerated populations, it is well known that the first two weeks of release from prison or jail are an incredibly dangerous time in terms of morbidity and mortality (Binswanger et al. 2007). This is not only from drug-related overdose and suicides, but

highlight the role of doctors—historically sometimes pejoratively called “dope doctors”—in this work. Physicians have much to gain from their participation in the burgeoning addiction treatment industry and not all doctors are engaged in ethical prescribing of addiction treatment medications.

also cardiovascular incidents and chronic disease. So if vivitrol could prevent even a percentage of the high prevalence of overdoses that occur in this time period, perhaps it could truly bridge people into community-based care or opioid maintenance therapy.

The danger with this approach, even if it shows great promise, is the way in which addiction and addiction treatment are linked with the prison and jail as a central organizing factor. It accepts the tenet that the prison and the jail is the space for the treatment and resolution of drug addiction in the first place. Recently, a judge in Ohio ordered that addicted defendants receive vivitrol shots in jail before release (McLaughlin 2013), and we must question whether the enmeshment of pharmaceuticals, prisons and drug treatment is a desirable situation.⁸⁴

Getting High On Medication

“Then we must ask: What is the nature of the psychic situation which makes acute the demand for elatants? What is the effect of this indulgence upon the mental life? What is there in it that makes the patient suffer? And why, in spite of the suffering, can he not cease from doing as he does?”

-Sandor Rado, “The Psychoanalysis of Pharmacothymia” (1933)

Whether it’s with suboxones or with OxyContin, incarcerated women that have addiction problems love to take them—often to feel “normal” and sometimes to get high. Several of the women I met in prison who eventually became addicted to heroin had first started on pills. Mae explained why doing pills was morally superior to heroin: “Pills are fine, you can do as many pills as you want, but the minute you switch to heroin, you’re a piece of shit.” Others echoed this fine-grained moral distinction, claiming that doing pills was also “safer” (and in fact, in many ways, it is, lacking the introduction of needles and bloodborne pathogens) and that

⁸⁴ The judge, Robert Peeler, had three defendants die of heroin overdoses after he released them from jail early. He was quoted saying, “They died because I released them. It’s impossible to keep them all in jail” (McLaughlin 2013).

everybody did pills of varying combinations. Pills lacked the symbolic moral degradation and the uncleanness that needles had come to represent in popular culture.

Another woman I met in prison, 23-year-old, Jennifer, a white woman with an acne-pocked face from the Lawrence/Lowell area, explained how she got into pills and eventually heroin:

Kim: So you started on pills?

Jennifer O: [Yeah], OCs, and me and Mike, the other one, of like seven years, um, we just, we were doing the coke and ecstasy a lot and our best friends, my best friend and his best friend, they were together before me and him were together, and we started realizing that they weren't hanging out a lot, and they were always tired, what was going on. We knew Oxy's had been around our town, but we were so against it, but everyone was doing it so we were like [emphasis added], what is taking our best friends away from us, so we started doing it, and ...

Kim: Why were you against it?

Jennifer O: Because at first, it wasn't as popular. We seen like, a group of people that we didn't associate with that we looked down upon... they were doing it. And we just...

Kim: So you guys got some and you did them together? How did you guys feel?

Jennifer O: We liked it. We liked it, and we started doing and eventually like two years later we were still doing them. And he started selling them. Sold them for years.

Later, she explains how she started to help sell them with her boyfriend, mostly in order to support their habits:

Jennifer O: I started shooting [OCs] when I was 17. Well we were living, me and Mike, we were living out of a hotel in Billerica, 'til one day, he took some of the money to go buy something. He was going to buy another jet ski and I was doing the business over the phone and someone broke into the hotel, robbed, beat me up, and took our safe that had all the rest of the money and pills in it. When that happened Mike's dealer, like his guy, said to change hotels, let the heat die down for a little bit, so over that time we were buying 10 packs. We were spending so much money buying 10 packs. We had to buy at least two ten packs a day just for us alone [to support our habits].

Kim: How much did they cost?

Jennifer O: Ten packs cost \$60 a pill [\$600]. Rather than when we were buying 100 of them, they were like \$30 a pill. We were going through so much money and my aunt, she's like my mom's best friend, kept saying, she said, why don't you try something else [heroin]? It's cheaper. And Mike is a steroid user so the first time we ever got heroin from my aunt, we shot it. Right away. Never sniffed it even.

Jennifer talks about how “everyone was doing it” so they were curious as to what was so great about the feeling. Yet pills also obtain part of their legitimacy by their relationship to medical authority. Even when an individual buys a pill on the street in order to get high, it is morally

differentiated from heroin. There is also a widespread belief on the street that taking pills is safer than taking heroin, like Eve had mentioned (Klein et al. 2003). Many users feel like pills are standardized, of a certain purity, and of a certain strength, to give a predictable high (as opposed to heroin, which can be cut with a variety of things that any level of dealer can choose to do).

Historically, women as a group have been large consumers of pills and have been attractive target markets for pharmaceuticals. Controlling women's emotional swings and surges with medication was seen as an important pharmacological source of intervention. In recent American history, this dates back to "mother's little helper" and the widespread use of tranquilizers and barbituates and amphetamines—often marketed as diet pills—in the 1950s (Campbell 2000; Metzl 2003). Women as a group are heavily prescribed narcotic medications, and recent studies have shown that women tend to use them in different ways than men (McHugh et al. 2013). McHugh's analysis found that women were more likely to have obtained opioids through a doctor's prescription than men; women also tended to report more functional impairment, higher levels of psychiatric symptoms, and an increased likelihood of using these medications to deal with negative affect than men.

A recent CDC analysis on prescription opioid use among women and overdose deaths showed that deaths among women from opioid pain medication use had increased fivefold between 1999-2010, a much faster percentage change than men even though men still comprised the majority of overdose deaths (Centers for Disease Control 2013a: 539). Accidental overdoses had taken over motor vehicle accidents as a cause of death consistently since 2007. The report noted that women were a special population to watch, given that women were more likely to be prescribed pain medications, use them over longer periods of time, and receive higher dose prescriptions.

Yet as with many public health endeavors, there was a lack of inquiry into why so many women wanted to “abuse” opioid medications. Why did they want to get high with opioids in the first place? What made it so desirable to “get wrecked,” as they say on the street? Why do so many women accidentally or intentionally edge into overdose and death while using these medicines, and sometimes doing it again and again and again? What are the socioeconomic, political, existential, bodily and/or psychological reasons that women choose to use these medications to excess? Why did Eve, for example, take three or four vicodins at once, instead of one? Why does Mae love taking heroin cut with Fentanyl even though it significantly increases the chance that she will accidentally overdose and die?

To understand the reasons behind these questions, one would have to be invested in an ethnographic excavation of relationships, of hope and curiosity, of the cultural and social production of and responses to psychological distress. These spaces of ordinary life and their unexceptionalism—when a woman feels unwell, for example, because she didn’t sleep through the night—this is the real space of drug use. It is where feelings blur with bodily experiences and reveals how women actually make do in the minutiae of their everyday lives. These are nebulous spaces indeed, the crevasses of ordinary experience. Legislators, politicians and even the medical community avoid these spaces at all costs; to do so would necessitate an existential inquiry into how we all go about life, and would make us all seem so startlingly human.

There was and continues to be something fundamentally off-putting about inquiries into individualized and interpersonal suffering in public health that tends to take population health as its object of study. It would mean acknowledging what is at stake for pharmaceutical companies, as a legal arm of the War on Addiction—the immense profits to be had—and the War on Drugs, where immense profits drive poor individuals to aspire to wealth, influence and fame (Contreras

2013). Everyone is caught up and knit together in parallel cultural logics of accumulation and the medication of distress. The consumers often do not feel their drug use is improper or illicit. The distinctions between licit/illicit and use/misuse (abuse) feel arbitrary, inconsistent, and morally fraught. Women who use heroin and other drugs—poly-pharmaceutical use, so to speak, for co-occurring drug disorders—will take substances procured from a variety of places: doctors, hospitals, friends, family members, dealers. Their bodies make no distinction. Yet the boundaries between the purported realms of ‘licit’ and ‘illicit’ are heavily policed.

With the flooding of prescription opioids and other types of addiction medicines, such as methadone and suboxone, onto the street and into the jails, women who use drugs say that all of them can be a way of getting high, particularly in combination (a particularly dangerous and attractive combination to drug addicts is a benzodiazepine plus an opiate). Neurophysiologists would say that they all clinically produce euphoria by acting on our neurons in the same way. But context is key, right?

I suggested to a 50-year-old woman who was getting ready to leave prison that it might be useful for her to enroll in a suboxone clinic upon her release in order to try to stave off a potential relapse to heroin use. ‘Won’t I get, you know, messed up?’ she whispered to me in a husky voice. She was worried that she would feel “high” since she hasn’t been using any opiates in the prison. I explained to her that the first couple of doses would be taken in the hospital (the “induction” phase) in order to monitor her and to help her adjust to the feelings of the drug in her body. The truth is that she would probably feel “high,” even in a sterile medical context where staff would monitor her physiological responses.

The question of where, and in what setting, opiates are taken, is critical. If this woman buys a suboxone on the street, she could risk arrest. If she takes one given to her in the hospital,

she is safe from the threat of incarceration. Many of the women I meet in the prisons are incarcerated on violations of the Controlled Substances Act—that is, for the possession of these drugs that are policed, that are not technically prescribed for them.

Kim: And what are you here [in MCI-Framingham] now for?

Annie: Possession of a controlled substance.

Kim: Which is what?

Annie: Class E. They're saying it was johnnies [street terminology for neurontin/gabapentin]. They're saying I had Neurontin, but I didn't have Neurontin. That's just what I pled out to.

Kim: What did you have?

Annie: I had Xanax but it was in my mouth and I ate the evidence... So I got six months for it. Six months for something I didn't really do. But you know, I'm guilty of something. Just not what they're saying I'm guilty of.

As Annie's case illustrates, the War on Drugs has rapidly expanding to ensnare people caught with a wide variety of medications, in this case a medication known as gabapentin that is traditionally used to treat seizures or neuropathic pain (on the street, gabapentin is thought to enhance the sedative effects of heroin or benzodiazepines, and is usually used as an adjunct but not usually by itself). In fact, she feels guilty by taking a Xanax that is not hers, for her illicit use and possession of medicines that are not her own.

Markus Dubber, a law professor at University of Toronto, argues that possession is a tool of a “disposal regime” of “millions of dangerous undesirables for offenses with no human victim whatsoever” (2001:3). He argues that possession has replaced vagrancy as the “sweep offense of choice,” (Dubber 2001: 6), designed to “incapacitate” social undesirables.

Alexis, a 27-year-old of Greek ethnicity, hailing from the New Hampshire/Massachusetts border, was also spending time in MCI-Framingham on a different kind of possession charge:

Kim: And how long have you been in here?

Alexis: Uh, 5 months. Almost five months.

Kim: Okay and what was that for?

Alexis: Possession.

Kim: Of heroin?

Alexis: No, Class B. Suboxone.

Kim: Really. So what's the situation? It's not yours?

Alexis: No it wasn't mine. It was in a friend's car... they were her granddaughter's prescription pills, and her granddaughter came to court with me and I was on probation, um, I was on probation and um, the judge violated my probation and stuck me in here for five months.

Kim: Um, and you were on probation for?

Alexis: Possession ... of Klonopins. I had some lymph nodes removed from my throat in the beginning of 2012 that had pre-cancerous cells in them....

Kim: So the Klonopins weren't yours?

Alexis: The Klonopins were mine, but they were prescribed to me for surgery. And they were in my purse, my wallet. And they...

Kim: They can do that?

Alexis: They can do whatever the hell they want.

Kim: How much probation did you get?

Alexis: 18 months of probation for 3 pills.

Kim: That's crazy.

Alexis: [laughing] Pretty much yeah. They screwed me over, oh yeah, big time.

Alexis' and Annie's cases illustrate how simple possession of so-called illicit drugs casts them into the prison system and the stigma, degradation and unhappiness that being incarcerated often entails. And being in the prison system also complicates and adds new depth to their relationships to drugs: women are introduced to new kinds of drugs, new ways to use drugs to get high, and are exposed to prison staff that believe that medicines are contraband.

Where Medicine is Contraband

Excerpt from Kim's fieldnote, June 24, 2013

When I arrive at the Suffolk House of Corrections today, there has been a shake-up overnight. The whole floor was tested for urines after some of the female inmates were caught smoking crack. The women involved were sent directly to solitary confinement ("the hole," as it is informally known inside). The women who were the instigators could be in the hole for up to one month for serious infractions, such as drug use. The primary perpetrator could even get an additional charge [more time on her sentence].

I ask the woman that I am interviewing what happened. She says that there was drug use on one of the two women's floors and they are doing urines on all the women. I stay away from that stuff, she says. They can smell you smoking crack, why would you do it, she says.

—

In the state women's prison, MCI-Framingham, drug use or the presence of drugs can be part of several levels of inmate offenses. According to the MCI-Framingham inmate handbook, a Category 1 offense, the most severe type, includes the "introduction, distribution or transfer of any narcotic, controlled substance, illegal drug, unauthorized drug or drug paraphernalia." The less severe Category 2 offense, 2-11, was just for using: "Unauthorized use or possession of drugs, narcotics, illegal drugs, unauthorized drugs or drug paraphernalia" (another Category 2 offense, 2-19, included the production of homebrew also known as hooch: "Making, introducing or transferring intoxicants and alcohol, or possession of ingredients, equipment, formula, or instructions that are used in making intoxicants and alcohol"). The punishments also included the act of just thinking about committing a drug crime, including "attempting to commit any of the above offenses, making plans to commit any of the above offenses or aiding another person to commit any of the above offenses," which are considered as equally serious as actually committing an offense.

Within the supposedly contained spaces of the prison and the jail, drugs are everywhere. Contrary to Erving Goffman's (1961) assessment of prisons as total institutions, closed off from the outer world and impermeable to outsiders, the contemporary prison is more like a semi-permeable membrane. Drugs and other intoxicants (some brought from outside, others made in house, like pruno, a fermented substance made by inmates with anything with sugar, like ketchup packets and canned fruit) are exchanged, bartered, bought and sold in the modern prison economy.

In the spring of 2013, the Massachusetts Department of Corrections ordered a policy change that reflected the perceived magnitude of the problem: they were introducing drug-sniffing dogs into the visitors' waiting rooms at all the prison facilities. They stated that they

were going to be utilizing specially trained narcotics dogs in an attempt to control the steady flow of drugs into the prisons. They argued that visitors, along with the mail, were the two main sources of drugs inside the prisons. As the DOC Performance Measures Division wrote, “A review of incidents involving the introduction of drugs by visitors over an eighteen month period of time showed that approximately half are identified as “one-time visitors,” individuals whose sole purpose is to enter the facility to introduce drugs. These visitors are often referred to as “mules.”” The dogs were an attempt to identify so-called ‘mules’ (Massachusetts Department of Correction 2013a).

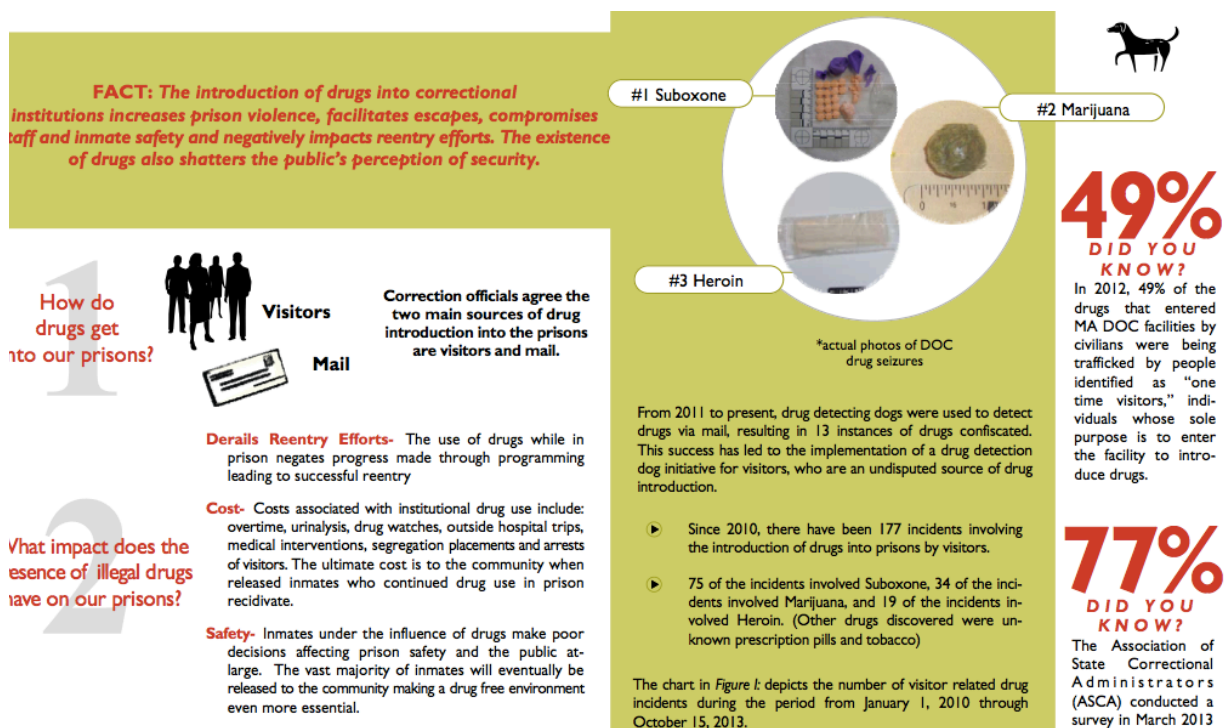


Figure 5.4: Department of Corrections’ pamphlet on drug dogs (MA DOC 2013)

The letter from the Commissioner, Luis Spencer, announcing the policy change to the prisoners, read: “The use of drugs many times is a root cause of criminal activity and continued drug use while incarcerated severely impacts your reentry efforts to return to the community better able to cope with the stressors of everyday life...While we realize that visits are an

extremely important part of your lives during your incarceration, the Department will not allow your reentry and treatment efforts to be derailed by illicit activities. It is our duty to do everything in our power to keep you and the correctional staff safe from harm” (Irons 2013).

The Massachusetts Department of Corrections started communicating when they would detect or locate drugs with the public via Facebook, Twitter and YouTube videos (see images below). It was all part of a coordinated attempt to project an image of security and policing of drugs (#drugsmuggling #greatjob).

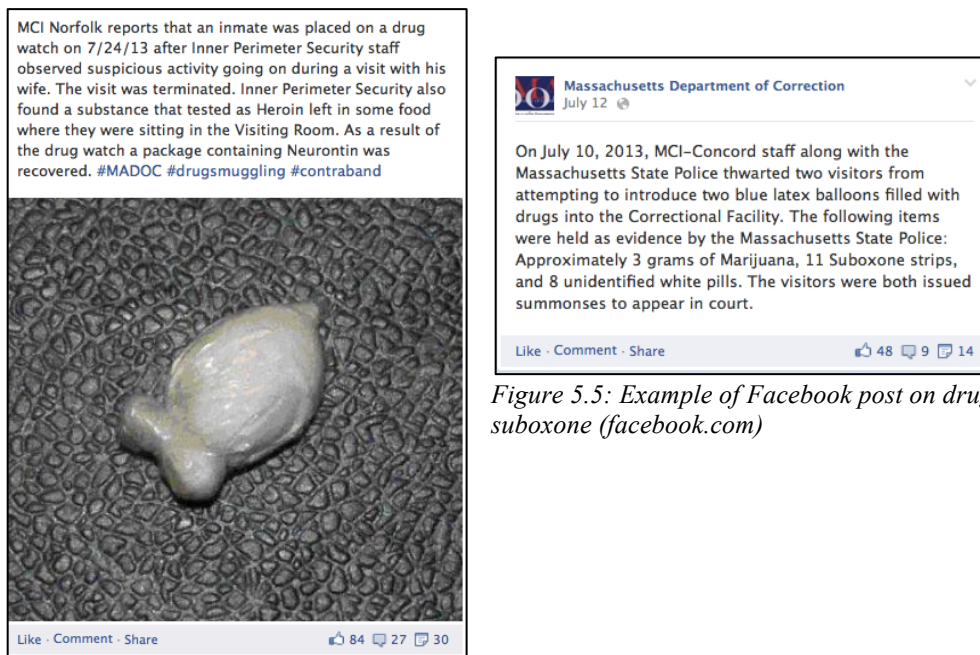


Figure 5.5: Example of Facebook post on drug smuggling suboxone (facebook.com)

Figure 5.6: Facebook post on smuggling Neurontin (facebook.com)

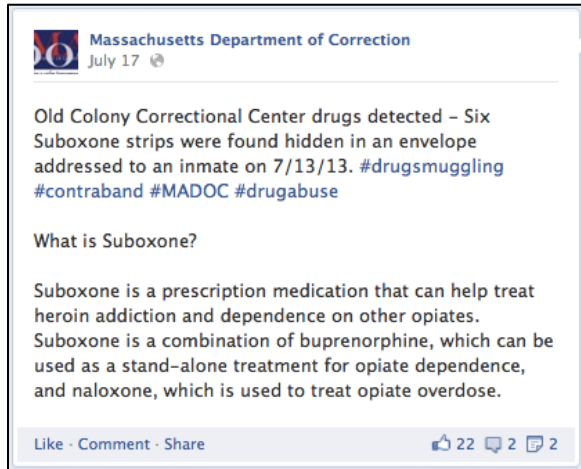


Figure 5.7: Facebook post #contraband (facebook.com)

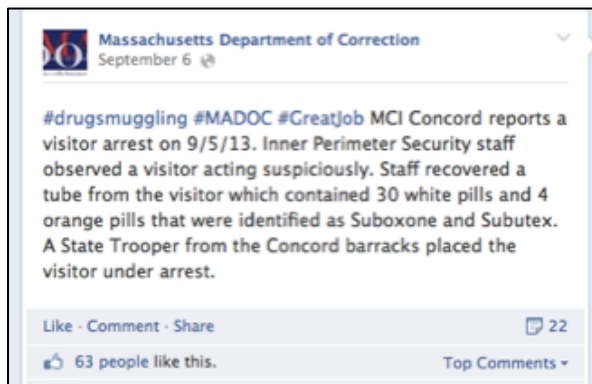


Figure 5.8: Facebook post #drugsmuggling (facebook.com)

Under the rhetorical maneuvers of “safety,” “reentry,” and “treatment,” the Department of Corrections initiated a new policy that largely blamed outsiders, families, and visitors for the widespread presence of drugs in the facilities, including, quite prominently, suboxone. The *Boston Globe* staff, in an editorial response to the policy change, suggested that “scaring away law-abiding visitors could hamper rehabilitation efforts” and that it “beggars

belief to think all drugs in prisons come from visitors” (Boston Globe Editorial Board 2013).

Where were the other half of prison narcotics coming from? ⁸⁵

Contraband, according to the DOC Performance Measures Division, “increases prison violence, facilitates escapes, compromises staff and inmate safety and negatively impacts reentry efforts. *The existence of contraband also shatters the public’s perception of security*” (emphasis added). The presence of drugs and drug use is thus punishable with fines, the loss of privileges, and time in solitary confinement. The presence of drugs, as the prison so aptly states, disrupts the order of things. It means that people are able to achieve a level of intoxication, oblivion, relief or escape from the punishment and ‘rehabilitation’ that they are supposedly receiving. The mere presence of drugs reflects the failure of the prison and its staff to maintain order, to establish an abstinent environment, to properly enact punishments and the deprivation of liberty. As Foucault has written, “The art of punishing... must rest on a whole technology of representation” (1995: 104). The Massachusetts Department of Corrections actively crafts a “technology of representation” literally using technology and social media in their Facebook and Twitter posts. Achieving a “law and order” public perception is critical in the work of punishment; in fact, it is everything. The presence of so-called “illicit drugs,” including medicines such as suboxone, critically damages public perceptions that the prison is a “safe,” “secure” environment where staff engage in “rehabilitation” and “re-entry” for hundreds of individuals with substance use disorders. It both reveals how fragile the philosophical tenets of the criminal justice system are and also hints at the fact that the prison fails to produce reformed citizens.

⁸⁵ An article in the *Philly Daily News* reported that a social service manager of the Philadelphia Prisons System had brought marijuana to inmates after 18 inmates tested positive for marijuana. Her lawyer was quoted as saying, “She did say that everybody [in the prison] does this... she wasn’t the first, and she’s not the last” (Polaneczky 2013).

For many incarcerated women, using drugs inside the prison is just another fact of life. They use drugs outside the prison, often in spite of the potential deleterious consequences to their health or their well-being, and they use drugs inside the prison in the same manner.

The symptoms of withdrawal are extremely unpleasant, but I've been told the mental anguish is worse than actually "kicking it." So inmates might become physically opiate-naïve after a period of a week or so, but the quest for locating and using substances to relieve emotional and physical distress—often a habit long-built up over a lifetime or many years—doesn't easily diminish. As an addiction psychiatrist, Edward Khantzian, has written, "A significant reason for the compulsion to use drugs is that individuals remember that the drugs provide control over and relief from intolerable emotional distress" (2011: 37). Let alone the stress of being isolated, alone, incarcerated, seized from one's community, friends and family with little comforts. As long as there is unaddressed distress, inadequate mental healthcare and addiction treatment, and as long as the criminalization of addiction leads to the incarceration of addicts, there will always be so-called illicit drugs in the prisons. In MCI-Framingham, the most widely available drug is the opioid maintenance medication, suboxone. It has become, in many ways, the drug of choice in prison. This is probably related to the tablet formulation as well as its increasing availability (contrary to what many physicians might expect, it is not used to help detox off heroin as in the streets but rather to get a mild high—it is difficult to get suboxones in the infirmary where most of the intense detox symptoms take place).

One of my close informants, Stacie, a 40-year-old white woman who was incarcerated in MCI-Framingham and now receives suboxones from her primary care physician in the community and has been clean for the past 4 years from heroin, tells me that, "Quitting opiates is the hardest thing to do. It's impossible to be on nothing. People keep saying, I don't feel right, I

don't feel right, and they relapse, relapse, relapse. You can't go from being amped up to being on nothing." I asked her if she took suboxones or managed to get them while she was incarcerated. She tells me, "No, I didn't use any in the prison. But when I was at the Sheriff's Station [after she got returned for violating probation] someone told her, "Hey take some of this." This woman was offering her suboxones. In a way, it was a gift, an offer of psychopharmaceutical solidarity to care for a fellow inmate in distress. "I did suboxone the last two months' at the Sheriff's station and it wasn't coming up on drug screens in 2005," she tells me. "It totally saved me. It helped me, helped me turn myself around." She thinks that smuggling suboxones into the prison can only help women with opiate habits inside, asserting, "I know that suboxone is the answer for a lot of people in there."

Mae, a white 22-year-old from a wealthy suburb on the South Shore, told me how and why she used suboxones while she was incarcerated at MCI-Framingham:

Kim: Have you ever been enrolled in a suboxone program?

Mae: No.

Kim: Have you ever bought them on the street?

Mae: Yeah. Not a fan of them though.

Kim: Because?

Mae: I don't like the taste of them, it's gross. And I don't know, I'd only do it if I was going to be sick [dopesick]...

Kim: Um... so you don't like taking them.

Mae: No, I mean if I'm in jail, when I was over there [in MCI-Framingham], I was like taking them just to get high, but...

Kim: Better than nothing?

Mae: Yeah.

Kim: How much do they cost?

Mae: One pill goes for 50 dollars.

Kim: One 8 [mg]?

Mae: Uh huh. Which is ridiculous because you can get them for no more than \$10 on the street but that's the profit you make.

Kim: At the pharmacy it's like a 3.50 co-pay for potentially a month's worth supply.

Mae: My boyfriend used to get them and his cousin, I used to sell them for him. And he'd get 90 of them a month, and that's \$900 off of one prescription.

Kim: That's a lot, yeah... So why would you do it inside?

Mae: In here? To get high.

Kim: Why did you want to get high?

Mae: Why not, you're sitting in jail, you know? I'm an addict, I like to get high, if it's offered.

Kim: How do people get it inside?

Mae: Um, people get it mailed in, through visits?

Kim: In a letter?

Mae: Like, you know those big orange manila whatever, they take the bottom off in the strips, they put it in the glue and send it in. A lot of people like the pills because you can either shoot them or snort them but they'll take the strips too if that's all you have.

Mae's mother is also a heroin addict. Mae shoots her mother up because her mother is too "dumb" to hit her own veins. Mae's mother was waiting to pick up Mae from prison when she left two months after this interview. Her mother had heroin for her waiting in the car; she didn't have to be sober a second longer than the car ride home. They drove back to their town high together. Mae's mother also helped Mae get drugs into these supposedly secure facilities. Like Angela Garcia observed in her work on heroin addicts in New Mexico (2010), much drug use is a shared behavior, a familial interaction, a product of mutual coping strategies. It is unfortunately how many family members learn to interact with each other and knits them together in illicit camaraderie. I asked her about how she could ever get clean with her mother purchasing the heroin:

Kim: Do you think for you to succeed you're going to not have to be around your mother?

Mae: Yeah, even other people tell me that. Because if I called my mom right now and said, mom come pick me up [from prison]. She'd try to fight with me, then I'd say, no, mom I'm going to be down the road. She'd be, "All right." Knowing that I'd get an escape charge but you know what I mean, she probably would. After she sectioned me, she sewed perc 30s into the bottom of my pants then brought them in. Bitch, you just sectioned me [involuntarily civil commitment for drug treatment] but now you're smuggling in drugs.

Prison doctors are another way that drugs flow into the prison's underground economy of psychopharmaceuticals. Many women are "legally" prescribed highly sought-after medications like benzodiazepines for medical conditions (like seizure disorders); they can "cheek" them, hiding their medications in different parts of their mouth, and then sell them to others. These drugs are widely available. Medication mismanagement was grounds for punishment, or a

disciplinary report (D report), for example if “an inmate engages in the unauthorized possession, accumulation or misuse of prescribed medication... or over-the-counter medications, vitamins, or similar products obtained via the inmate canteen” (Massachusetts Department of Correction 2013:14).

In fact, as sociology professor Susan Sered has argued, women in prison are prescribed psychoactive medications at rates that are much higher than male prisoners. In her research on women in prison in Massachusetts, she noted that 56% of women inmates were treated with psychotropic medications (compared to 12% of men); she worries that “these drugs often function to restrict autonomy in much the same way as shackles and solitary confinement” and that the use of these medicines “draws attention away from the social miseries that lead to pain, disability, illness and the need to do whatever it takes to survive” (Sered 2013).

But they are not just a means to quell potential disruption or bad behavior. It is always more complicated than that. The prison doctors are seen as resources for the women; they have substances that will soothe distress and bodily discomfort. It is up to enterprising women to figure out how to get substances, not only for themselves, but also to barter in the prison’s internal market. Alexis, the young Greek woman I met in prison, tells me that she first got introduced to benzodiazepines in prison, partly through a trick of her own:

Alexis: That’s where I discovered benzos was in here. In Framingham. This is where I discovered benzos.
Kim: You bought some? Someone gave them to you?
Alexis: They [the medical staff] gave them to me because I told them I was on them. I got on the taper when I first came in. In ’09. And I left here with a fucking bad habit because I kept buying them off other girls.

She then considered benzodiazepines as a necessary part of her ongoing health concerns, even though the concurrent use of benzodiazepines and methadone could cause her to overdose and die. And many psychiatrists consider benzodiazepines a legitimate treatment for anxiety.

Kim: What do you consider to be the biggest health problem you currently face?
 Alexis: Probably my anxiety. I have very bad anxiety, yeah.
 Kim: Do you think you've ever found anything that works?
 Alexis: Yeah, I need fucking benzos, that's what works.
 Kim: And your doctors on the outside do they prescribe you benzos?
 Alexis: I get boatloads! [laughing]
 Kim: And what's the main source of your income?
 Alexis: I usually work.
 Kim: Do you ever sell your benzos?
 Alexis: Nooooo. I need every one of those. I'm a walking frigging heart attack waiting to happen [laughing]

Alexis and others were also critical of the prison staff for policing and trying to seek out drug use in the prisons. The inmates believe that the prison literally profits off of detecting drugs by taking the personal money of inmates as punishment.⁸⁶ As I wrote in one of my fieldnotes:

2013-05-28 I learned today from two women at SMCC [South Middlesex Correctional Center] that the women keep dying. They keep overdosing. They knew at least five women between the two of them that had gone out and died... We are talking about suboxone and how that's the drug of choice in prisons over there (MCI-Framingham). They tell me how there is a financial incentive for you to go to the hole. They get something like \$140 from you—from your account, from your canteen, and if you get money sent to you, they take it from you until it's paid off. So they don't treat addiction like a disease, instead they punish you for using. There is very much a pejorative sense that using suboxone is like using a drug inside. The other girls think: Why can't you control yourself when you're inside, when you're in prison, when you're "clean"?

Brittany, who is at MCI-Framingham for being her town's local Percocet drug dealer, explained that they charge \$140 for the first dirty urine, claiming that it is the price of the drug test. Yet they don't charge you for the drug tests that you pass, she says. Then they double the price for the next dirty urines: \$280 for the next one, etc. They take the money out of the inmate's account, and generally freeze the canteen money until the inmate's debt is paid off to the prison.

⁸⁶ According to 103 DOC 525, the Massachusetts DOC Inmate Substance Abuse Monitoring and Testing protocols, "Substance abuse monitoring shall be conducted for both security and treatment purposes" (2013:4). Inmates were tested based on their profiles, including disciplinary histories, drugs of choice or mental health history, medical orders or the COMPAS assessment based on "the inmate's drug of choice, specific intelligence, or current drug use trends within the institution" (2013: 5); those more frequently tested included individuals in treatment programs and those on the "monthly suspect list" (2013: 11) or those returning from work release.

The Department of Corrections explains that inmates can either plead guilty or take a confirmatory test from the outside laboratory: “If the confirmatory test supports the positive initial screening result (s), the inmate may be held responsible for restitution regarding the cost of the confirmatory test(s)...” (2013:14-15). The amount of restitution is determined at the Disciplinary Hearing and the inmate must agree to pay for future mandatory monthly urine tests at her expense. She does not have to pay anything if the confirmatory test is negative (2013: 15). If positive, the funds are seized by the Treasurer.

To go without canteen is a sad fate. The canteen is the lifeline of physical and material comforts for most women, offering weekly goods and supplies that one would normally procure at a drugstore or a grocery store like instant tea and coffee, candy, soap, shampoo, sweatpants and shoes. So losing canteen is a terrible blow to well-being and can greatly impact the ability of women to tolerate the vagaries of prison life. Much is at stake for women if they lose access to canteen, especially if they are depending on money being sent in from the outside. To be charged for dirty urines is a harsh form of punishment, and women perceive it as the prison profiting off of ongoing untreated drug use and addiction, but even the threat of being cut off from canteen doesn’t stop many women from wanting to get high to escape the drudgery of the place that contains them.

Conclusion: Criminalized Subjects

Arjun Appadurai notes in his now classic work on the social lives of things that we have to realize that “changes in consumption, if not inspired and regulated by those in power, are likely to appear threatening to them” (1986: 28). Diversion, he goes on to argue, “is only meaningful in relation to the paths from which they stray. The challenge is to define the relevant and customary paths, so that the logic of diversion can properly, and relationally, be understood”

(ibid). Diversion of medications for use/abuse in the prison and on the streets has been encompassed into the calculating and punitive War on Drugs policies, as seen by the Massachusetts Department of Corrections' Facebook and twitter posts. Diversion is labeled as “abuse” or “misuse”; it is painted as bad, morally egregious and criminal. It increasingly indicts physicians for lax clinical judgments and patients as drug-seeking.

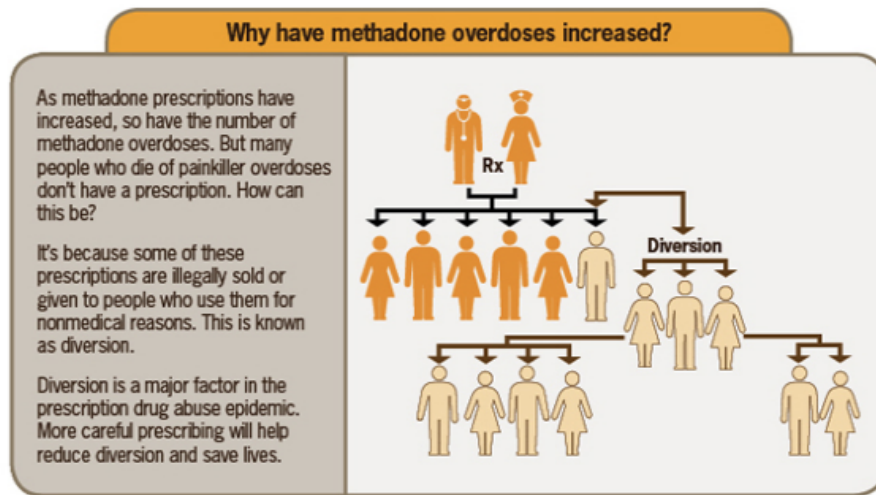


Figure 5.9: CDC diagram illustrating the relationship between physicians and diversions to the streets (CDC Vital Signs 2012, Prescription Painkiller Overdoses)

But the focus on diversion gives the government the ideological basis from which to police, punish and intervene on the individual offenders who sell or “abuse” medications rather than interrogate why there is an unending demand for them. The substances themselves take on certain colors, inflected with the moral reasoning of those in power, those who are doing the punishing and policing. Just as often as suboxone is being touted as a medicine by physicians and public health officials, it is being denounced as dangerous contraband by the Department of Corrections. The government gives itself, as well as for-profit pharmaceutical, drug-testing and criminal justice industries, the legitimacy and means to police medicines—how and where they go, and how they are consumed and by whom.

Diversion, or “pharmaceutical leakage” as Anne Lovell calls it, is inevitable. Psychopharmaceuticals are an important “medium of exchange” in the streets and the prison that reflect not their only precious value but also the relationships and institutions through which they flow (DeVecchio Good 2010). The increased policing of diversion does not account for the moral economy in which these drugs flow from physicians outwards, responding largely to the moral panic over prescription drug use among white, middle-class drug users like Eve.⁸⁷ The increased policing around diversion contributes to the ongoing suppression of an already destitute class of people in this country. Poor drug addicts engage in self-care and self-medication using suboxones and other medications, and they are made into even further abject subjects of the state after incarceration. They come to feel “guilty” as Annie told me (“I’m guilty of something [having Xanax on her]”), internalizing the badness and immorality that the state espouses is inherent in their characters, in their drug addictions.

Yet only some women experience the criminalization of addiction and addiction treatment and the resulting subjectification of incarceration. Eve wonders why she never went to jail. Now she works a full-time job at Walgreens and hopes to go back to finish college at Northeastern, where she had completed one or two years. She tells me, “Towards the end [of her addiction], it was ugly... we robbed drug dealers, it was not pretty. I got lucky that we didn’t go to jail. I got arrested shoplifting... I could have gone to jail, I just didn’t. Thomas bailed me out, it was cheap, like fifty bucks or something.” Yet it was not just luck, was it, I wondered. Eve’s partner had the ability and wherewithal to get fifty dollars to get Eve out of prison. They had the resources to show up in court and to argue that the case should be dismissed with a fine and no legal record (it was). After she was hospitalized with endocarditis, a life-threatening bacterial

⁸⁷ See Matthew Durlington’s thesis on racialized moral panics and heroin use in suburbs of Plano, Texas for an excellent ethnographic work on media and drug use (Durlington 2002).

infection of the heart valves, Eve's family allowed her to come back home and mandated that she have inpatient treatment. Her mother, a registered nurse by training, drug tested her randomly. And while Eve's health was significantly affected by her drug use, her life chances—in terms of her ability to exit a life of drug use and ongoing suffering and misery—were high. Now Eve has over a year clean from opiates. She feels like she could have slipped from the 'good' category into the 'criminal' category, but there were social and cultural reasons she did not (her whiteness, her social support, her high level of education).

Eve stands in contrast to many of the women who cycle in and out of prisons and struggle to get ahold of their opiate addictions. The women in prison learn that they are bad; why can't they "get themselves together"? They internalize badness; this absolves the state from recognizing and addressing the social and political conditions that fuel addiction, poverty and abjection. The ongoing criminalization of psychopharmaceuticals and addiction treatments fuels these moral economies of affliction, continuing to mire women in the criminal justice system and a status as second-class citizens as they partake in consuming an expanding realm of medicines to alleviate socially-produced distress.

Chapter 6:
Discipline, Punish, and Treat Trauma?
Women, Addiction and Carceral Technologies of Rehabilitation

“ I don’t know how I be doing it, I don’t even know how I survived this long, I’m serious. Like I don’t even know how I’m still alive right now, the stuff I’ve done, the stuff I’ve been through, from birth. The life that I’ve lived, no support, you know what I’m saying. ”-Alisha, 29-years-old

Psychopharmaceuticals are one common orientation to the treatment of addicted and criminalized women in the prisons and jails. Another approach is through the lens of trauma. Trauma, whether it is explicitly addressed or not, trickles into the interstices of the prison and the jail. Trauma is at the core of prisons and jails everywhere. It hangs deeply in the cement cinderblock walls; it rears its head when there is a dispute about who is going to sleep on the top bunk and who is going to sleep on the bottom bunk and someone goes to the “hole” because of there is a fight and she refused to back down.

Prisons must confront, manage, and directly or indirectly address trauma on an everyday basis on multiple levels. In the past fifteen years in Massachusetts and similarly around the country, there has been a shift in correctional trends to explicitly responding to and treating trauma (Bloom, Owen, and Covington 2003; Greenfield and Snell 1999). In 2005, MCI-Framingham sought to become a “trauma-informed prison” (Dennehy 2005).

Yet why was there a turn to trauma in the prison systems and what were implications of doing so? This chapter seeks to understand how trauma has become embedded into the prison as both a cause and an effect. It begins with an exploration of the high prevalence of trauma in the lives of women who use drugs using the case study of a woman I call Alisha. Why are women who use drugs so vulnerable to experiencing trauma, and why do people who have early childhood traumatic experiences face such increased risks for becoming drug addicts?

Then I will explore the increasing presence of “trauma talk” in the women’s prisons and jails, as there has been a rhetorical shift among the institutions towards the provision of “trauma-informed services” and a “trauma-informed criminal justice system” (Elliott et al. 2005; Substance Abuse and Mental Health Services Administration 2011a). Administrators and program officers in the prisons now can articulate why trauma is important and how it affects the daily work of the prison, but how does this change the daily experience of incarcerated women with addiction, if at all? I am particularly interested in how incarcerated women come to conceptualize their life histories as traumatic histories. How does this rhetorical turn to trauma play out when women leave prison, as they face the risks for re-traumatization and resumption of drug use?

Finally, I will look at the political-economic and historical reasons that the prison is a place for the ‘treatment’ of traumatized, generally impoverished women for drug addiction. In other words, what are the social conditions and legislative policies that have made the prison a place for *de facto* mental health and trauma treatment in the first place, and what are the unintended consequences of re-siting trauma treatment into a carceral space? Looking at both the critical theoretical concerns as well as practical matters, I seek to explore the “place” and “space” of the prison as it attempts to “treat” poor women with drug addiction. How do recent anthropological examinations of trauma and trauma treatment, as well as trauma as a popular discursive maneuver and trope, shed light on trauma work being done in the prisons in Massachusetts?

Alisha, one of the women that I met while she was incarcerated the Suffolk House of Corrections in Boston, attributes her chaotic life to when her mother first tried to kill her as a

newborn baby by stuffing bottles down her throat. Her mother, who would later be diagnosed as paranoid schizophrenic, was sent to live in a group home for the mentally ill in Upham's Corner in Dorchester. Alisha went to live in Orchard Park to be raised by an aunt. Orchard Park is a tiny but densely packed public housing project located in Roxbury just south of Boston Medical Center. At the time, Orchard Park had a reputation for being the worst of the worst, populated by drug dealers and sex workers openly hanging out on the tiny lawns of the housing projects.

"You come out in your hallway, you see people shooting up in the stairs, people smoking crack on the stairs. Plus, like I was seven, and I used to be outside with the older guys. They'd be like, Alisha, I'll give you a dollar to stash my gun in the dirt. Put it over there, they're going to go over there I'll give you two dollars. I was literally doing that."

Alisha became pregnant by her 15-year-old boyfriend when she was 11-years-old. She was sent to a juvenile facility run by the Division of Youth Services (DYS) for her participation in an armed robbery when she was 11, but only after her boyfriend's mother had signed papers "to be my mother to get an abortion." She does not remember DHS as being a particularly terrible place for her. With her sunny disposition and dimpled cheeks, she made many friends with whom she started "crushing up the pills and sniffing the pills [whatever kind of pills they were]." So she reflects, "My addictive behavior started when I was real young." All her schooling was conducted at DHS. "The last time I was in a public school was elementary school," she says wistfully.

After she left DHS, Alisha returned to Orchard Park and sold drugs, mostly marijuana. She was smoking cigarettes, drinking and smoking weed, like most everyone else her age was doing. When she was 13, she met a 19-year-old man named Diego. He was originally from Honduras, and when she got sent back to DHS for another infraction (she thinks it was

participation in another armed robbery), he would send her candy, letters, and love notes. She moved in with him when she was released because he was so doting and affectionate and she had not felt that kind of love before.

Diego would leave her for days on end in their dark, one-bedroom apartment in Dorchester and “it got to the point that he was putting his cousin’s dogs outside the doors because they didn’t know me, so if I opened the door they would bite me because they didn’t know me.” He would beat her for any reason imaginable: for what she was wearing, what he thought she would do with other men while he was away at work. She reasoned, “It’s weird, I did know at some point, he did love me in a way, I just don’t know if he knew how to show it... He made sure I had clothes, that I ate, that I had sneakers, he took care of me.”

This relationship with Diego was the first of many dysfunctional relationships in Alisha’s life. He began to beat her more and more often: “He’s stomping me. He’s beating my ass. Beating me up... He would accuse me, like I would go into the store or something like that, and I would take too long to come back from the store and he would just flip out on me.” The chronic beatings turned into an explosive act of violence against Alisha and her family.

Eventually, Alisha tried to leave Diego and return to her home in Orchard Park. She recalls that eventful day: “He went crazy. He knocked my sister out, punched her in her face, knocked her out. Tied up my mother [aunt] with the phone cord, cut the phone wires so that nobody could call the police, and he dragged me down. I remember him, [he] dragged me downstairs by my hair just beating the shit out of me. My neighbors in the projects had called the police. He let me go, he tried to get me in the car, and I was just fighting him...He ended up getting in a police chase with the police and he went to jail for four years and that was the end of the relationship.”

Her next relationship did not fare any better. She met Dynamite, a charming man who was 37 years old to Alisha's 17. He was a pimp. How do you know he's a pimp, I wondered? "Cuz, I grew up in the projects, I know pimps... They're lady men, they dress a certain way, they're smooth." He started to pimp her out "in a way so I didn't even see it coming" that drew on the lofty ideals of their love and their economic partnership. She was being pimped out in Downtown Crossing when it went by the infamous name "The Combat Zone." She speaks wistfully about what Boston's downtown was like at the time: "In the summertime, it used to be popping. You got women from all over, from California, from Michigan, from here and there, everyone's hoing out, you got women there competing, you got traffic jammed up... I loved it."

Alisha would do whatever Dynamite told her to, "out there, selling my butt, doing all kinds of shit." Their relationship ended violently after Alisha's cousin, Tommy, got out of jail and found out that Dynamite was pimping out his "favorite little cousin." Alisha recalls being in the car with Dynamite, getting ready for "work." She saw another car driving towards them, carrying Tommy and his baby's mother. Tommy started "beating [Dynamite] down, with a gun" and "I'm beating up his baby's mother because I'm so in love [with him] and I'm mad because she told [on me] and I'm pissed off so I ended up stabbing her. So she called the police [but] said that he stabbed her. Dynamite was already out on parole for white slavery."

When Dynamite got sent back to prison, Alisha was out on her own without a pimp, a situation that is known as "renegading." It was a potentially very dangerous situation: "I got pimps trying to get at me, because they're like, her man's locked up, what the fuck is she doing down here. They're trying to rob me, I was making thousands of dollars a night... To make a long story short, I met this girl named Jade. She's from New York, she's a butch [lesbian], and she has clientele." Alisha and Jade fell in love and Jade introduces her to high-end clients that

paid up to \$500 an hour. Their relationship lasted only a short period of time before Jade was extradited back to New York to do a four to five year bid for drug-related activities.

Alisha, in the meantime, had acquired a bad cocaine habit. She had originally only done “oolies” (marijuana cigarettes laced with cocaine) but had moved on to sniffing coke. Alisha used all of Jade’s stash that was left at their house (she was not as good a drug dealer as Jade, since she basically did all the drugs she was meant to sell). Doing all the cocaine made Alisha increasingly paranoid and she looked around “to find something to bring me down.” An older man she knew introduced her to heroin and she liked it: “I was like word, now I feel balanced, I’m not bugging [paranoid], my heart’s not racing, I feel like I can function.” Eventually, she stopped using the heroin just to bring her down after her cocaine binges and “it got to a point where I didn’t want coke, I wanted dope.” Of course, Alisha had developed physical dependence to opiates and no longer even desired the cocaine.

Alisha continued to work the streets, this time in the black projects in Dorchester instead of Downtown Crossing. She was no longer doing high-end sex work and had acquired a significant heroin addiction, although she was only sniffing it, never shooting it.⁸⁸ The street was the source of many traumas that Alisha still cannot shake and that still continue to haunt her. For example:

This guy, I was trying to make money, and I got in a car with this guy, you know where Heath Street is [on the Jamaica Plain/Roxbury border]? Heath Street? You know how there’s a field over there, we went over there, and I was getting in his van and I looked up, he had a gun pointed at me. He had a pillow on his backseat, and he kept saying, Alisha, it’s gonna be quick. He was beating me with the gun, we was fighting, I was fighting, fighting and fighting, and all I remember is like, he kept trying to put the pillow over my head. Saying, Alisha, it’s gonna be quick, it’s gonna be quick. And I was going crazy. I remember biting him, I remember he had a tattoo where I bit him at. I bit him and all I remember is like being kicked out the van like, I had blacked out. He didn’t kill me because I guess he

⁸⁸ It is interesting that Alisha never progressed to shooting heroin given her physical dependence. When I asked her about why not, she espoused that she never liked it and was too scared about dying. As a consequence, she had to do much larger amounts to feed her heroin addiction via sniffing/snorting. She also was at greatly decreased risk for Hepatitis C and HIV (she has neither).

knew if he would have killed me, his DNA would have been all in my teeth, so I just remember waking up in the middle of the Heath Street projects with no clothes on, he had stripped me naked, I had no clothes on, and these guys, these Spanish guys was riding by and they called the police, they called the ambulance and shit like that. But I was dopesick and I didn't care. I had so many gashes, there was blood like pouring out my head. I still have gashes all on my head now... [but] I didn't go to the hospital. They gave me sheets, saying you have to go to the hospital you're bleeding out your head, you need stitches. I signed this thing on his computer, the police are like where are living, I said I live in Orchard Park, and I got in a police car and they dropped me off at this random house in Orchard Park that I told them I lived at and I didn't, and I remember I was, asking at a different door because I was [dope] sick, he wouldn't give it to me...

This is not the only time that someone has tried to murder Alisha. And not much has changed in the last twenty years in her life: violence, drug addiction, instability and incarceration are such regular aspects of her life that she does not see them as exceptional—this is what Arthur Kleinman (2000) has called the “violences of everyday life” and what Veena Das (2006) has called “the precarious nature of the everyday.”

Getting locked up is a predictable occurrence in her life. All the guards at Suffolk House of Correction know her by name. She has grown up alongside the baby-faced guards who first policed her cells; now they have been promoted to lieutenants and sergeants and no longer do the stressful and time-consuming front-line jobs in the cellblocks. None of her life circumstances are significantly different each time that she leaves prison (by her recollection, she has been incarcerated approximately twelve times or more), but this last time, she is coming to realize that her life is defined by trauma “just from going through everything... I’ve been stabbed, I’ve been in mad shit. Everything that I’ve been through I’ve been through myself, no family, nothing.”

Through the various kinds of programming activities that she has completed at the jail, Alisha has adopted a “trauma-informed” lens through which she can examine her own life circumstances. This last time she is in jail for about eight more weeks before she could potentially be released on parole; she has to complete an “anger management” class as a

stipulation of getting parole. She decides that she wants to go to a domestic violence shelter in order to get help for her issues. She could always go stay with her latest boyfriend (she always has a boyfriend or a girlfriend since she is good at “using men for money”), but this time, she wants to “get on feet, do my own thing... and work my way to the top.”⁸⁹

Alisha tells me that she thinks prison works “if you want it to work.” So why is she back here again, I ask her? “The lifestyle.” How does prison “work” exactly, I ask her. She tells me, “Because prison lets you sit, think, plan, you know what I’m saying. And it gives you other opportunities like learning things about yourself, you have therapy, you have groups, you know, you can get your health checked out here, [get an] HIV test, you know, shit like that.”

—

I tell Alisha’s story here to represent the depth, chronicity and magnitude of traumatic events in the lives of women with addiction. How can the prison, or even the most specialized healthcare institutions in the community, for that matter, attempt to get a handle on her suffering and even begin to think about treatment? What can be hoped for in imagining Alisha’s life after prison? Is prison the only place amongst all our social institutions where the poor and disadvantaged can sit, think, plan, have therapy and get their health checked out?

A World of "Bad Hits": The Uneven Distribution of Traumatic Experiences

Kim: What do you think is the great health problem you currently face?

Serenity: You might think my HIV, but it’s my depression and trauma. I have flashbacks. There’s no pill you can take to stop that feeling of hopelessness or desperation, nothing you can do for that.

For women in prison, the concept of trauma does not perfectly align with formal psychiatric definitions. Rather it encompasses a sense of constant material and relational

⁸⁹ Alisha tells me she wants to “work with animals” or “be a speaker” about growing up in a rough neighborhood.

uncertainty in spaces of extreme marginalization. It is not a term that they are accustomed to using to describe their life histories even though women were marked by enduring psychic and sometimes physiological harm. I discovered rapidly that I was in the business of chronicling traumatic experience and ill-fated attempts at managing suffering and distress.

Women used the term trauma and PTSD almost interchangeably.⁹⁰ PTSD was part of a long list of mental health diagnoses that they had been given throughout their interactions with mental health providers over the years. They tended to use “PTSD” loosely as “pervasive idiom of distress” (Summerfield 2001:98), much in the way that Joshua Breslau has noted, as “a prominent cultural model for understanding the suffering that can be caused by a wide variety of traumatic experiences, from automobile accidents to childhood sexual abuse” (2004:113). And while they did have physiological disturbances, they tended to not have the characteristic embodied physical signs (hyperarousal, hypervigilance, irritability, intrusive thoughts and flashbacks). Most commonly, women mentioned sleep dysregulation and nightmares, if they mentioned anything.

Early in the development of the concept of PTSD for the DSM-III in 1980, theories of trauma presumed that trauma could happen to anyone; there was no pre-existing personality traits or character flaws that made one vulnerable to developing the disorder. The medical community has now evolved significantly away from that viewpoint. A recent article on trauma published on a popular online resource for physicians, *UptoDate*, reads: “Personal and societal factors appear to

⁹⁰ Post-traumatic stress disorder, otherwise known as PTSD, is a relatively young psychiatric diagnosis—just over 30 years old. It has evolved significantly over the past three decades and fundamental orientations to trauma and trauma treatment have undergone significant changes. Revisions to the diagnosis of PTSD in the DSM-V included exposure to one of a wider range of scenarios outside of directly experiencing a traumatic event or witnessing one in person; a PTSD diagnosis could come from learning about the traumatic event of a close friend or family member or experiencing repeated exposures to details of a traumatic event (American Psychiatric Association 2013). The related symptoms include one of three general categories and usually experiences symptoms in all categories: (1) re-experiencing in the form of nightmares or flashbacks (2) hyperarousal, such as difficulty sleeping or concentrating; and (3) symptoms of withdrawal such as avoiding other people or emotional numbness.

affect both the likelihood of developing PTSD after a traumatic event and the clinical presentation of PTSD. Risk factors for PTSD include lower socioeconomic status, parental neglect, family or personal history of a psychiatric condition, poor social support, and initial severity of reaction to the traumatic event” (Ciechanowski and Katon 2012). The article goes on to state that some people who experienced early traumatic events seemed to experience more and more trauma, that is, they were, in physiological terms, "sensitized" by an unknown mechanism.

Trauma is a compelling paradigm that links the macro level (historical, ecological and political disasters of both sweeping and small scales as well as their aftermaths) and micro (the clinical and biographical aspects of affected individuals). It can speak to a communal atrocity, violence and slavery (Langer 1991; James 2010; Abramowitz 2010; Kennedy 2011; Eyerman 2001) or to the complex aftermath of memories and emotions (Caruth 1995; Caruth 1996). As Allan Young (1995) has pointed out, PTSD has scientific credibility and plausibility so that a wide range of actors and social institutions appropriate these discourses for particular interests and means. This maneuver often elides both the role and effects on perpetrators and victims of trauma alike; as Ruth Leys writes, “The model implies that all participants in war... are alike casualties of an external trauma that causes objective changes in the brain in ways that tend to eliminate the issue of moral meaning and ethical assessment” (Leys 2000: 7).

But not everyone is at equal risk for traumatic events and not everyone is equally predisposed to trauma. And only some people experience recurring traumatic incidents and exposures. This is not a level playing field: those who are more vulnerable to the vagaries of life, who have less social support, less financial resources, and less ability to shelter themselves endure a much larger burden of trauma in their lives than those who are more well-off. The epidemiological distribution of trauma, much like contemporary public health practitioners have

argued with relation to gun violence (Slutkin 2013; Webster and Whitehall 2012), must be thought of as an accretion of geographical and class-, race- and gender-based historical inequalities and social injustices.⁹¹

The traumas and tragedies I recorded and encountered in prisons and jails distressed me in their ubiquity, quality and quantity. Some stories were about the slow and insidious depravations of childhood neglect or being forced to parent younger children while a parent used drugs; others spoke to witnessing or experiencing acts of violence or close encounters with death. The sheer magnitude of traumas endured by the women I encountered in prison was overwhelming for me to absorb.

Sadly, Alisha's story was not an atypical life history. Among women in my small sample, only three women denied experiencing either acute traumas (taking place within the last year) or a history of a traumatic or neglectful childhood.⁹² These statistics corresponds with larger epidemiological studies that have shown that up to 80% of women with substance use problems report a history of physical abuse, sexual abuse or both (Fullilove et al. 1993; Greenfield and Snell 1999; Bloom, Owen, and Covington 2003; Walsh et al. 2012). Rates of women with both substance use and PTSD range from 30-59% (Ouimette et al. 2000; Kessler et al. 1995; Teplin, Abram, and McClelland 1996) and these women tend to experience a fragmented community treatment system (Grella 2003). The relationships between childhood and adult traumas and neglect, substance use and involvement in crimes of survival are becoming increasingly clear (Golder 2007; Vaddiparti et al. 2006; Horowitz et al. 2001).

⁹¹ Interesting treatment interventions based on historical and cultural trauma have been developed; see Robert Morgan's work on substance use with Alaskan native and American-Indian people in Alaska (Morgan and Freeman 2009).

⁹² The three women denying trauma histories were all white, between 25-35 years old, and all solidly middle class. One is now clean with the help of suboxone and therapy and holds down a steady full-time job; one who is back using heroin and selling heroin in New Hampshire; and one, who is also on suboxone, has slipped up occasionally but is living with her family on the South Shore and working as her grandfather's caretaker.

These women moved from and within varieties and realms of traumatic experiences: physical traumas/accidents, rape, getting hit, having ongoing unsafe relationships. Their methods of coping or managing trauma were additionally harmful or self-injurious. They were generally able to list off a litany of horror stories that were just the plain facts of life. What shocked me was frankly nothing exceptional. When women would mention trauma or PTSD, I asked why they had been given diagnoses of PTSD. I received responses like these (quoted verbatim from interviews):

-“I’ve had a lot of traumatic stuff happen in my life. I lost 13 friends to suicide when I was 14 [years old] in South Boston... then when I was fifteen I saw my mom get raped.”

-“I found my uncle when he killed himself in 1988. Actually that gave me really bad PTSD. Just from being in prison, and my father, not having him around. My grandparents dying. I have a lot of traumatic events.”

-“My girlfriend was murdered and that fucked me. That was back in 1995, for five years I walked around like a lunatic.”

-“Um, I was raped when I was in the army. When I told my sergeants about it they told me it never happened and to get the hell out of their office.”

-“I think it’s [related to] my boyfriends beating me up, seeing my parents fight, being left in places when I was kid [while my parents were out doing heroin and cocaine]”

-“I’ve been raped a lot, a lot of times. And you know, being out there, selling my body, people say, well what do you expect? What do you expect? Still, you know, it’s traumatic to have, like, five guys hold you down.”

-“I have post traumatic stress from my [car] accident [where I lost my leg].”

-“My father was very abusive, in every way. Sexually, mentally, physically. And he would take rice and throw it on the hardwood floor and make us kneel on it for hours. If we got a C on our report cards, and mind you, I’m only ten years old at this time, he made us clean the whole house. So my sister had once got a C and that’s what happened to her, and she got beat with the belt.”

Thematic analysis reveals a wide range of traumatic experiences. Women who use drugs sometimes refer to these unfortunate experiences as “a bad hit,” meaning any time something goes wrong. Sometimes it means that they literally got “screwed over” with weak drugs (“garbage”) or an incorrect drug (“a bad bag”) or a smaller quantity of drugs than had been advertised and paid for, but more generally it is street terminology to reflect the perception of unfairness in one’s lot in life, one got “screwed.”

Mae recalls that it was a “bad hit” when her mother sectioned her for drug treatment. Faith recalls the news of her beloved grandmother’s death: “That was a bad hit, because she was my best friend, she had played the mother, so that still hurts, hard. She had left me a lot of money, and I spent every penny of it [over \$100,000] on drugs and have nothing and almost lost [her] house.” Not all “bad hits” are on the level of serious traumatic experience; most women consider “bad hits” everyday, micro-level insults. But thinking about the prevalence of really “bad hits” and the severity of them in the lives of women who use drugs demonstrates the unevenness of trauma experiences. Thinking through a lens of “bad hits” allows us to affirm women’s own sense of injustice and unfairness in life; it is a phrase that can talk back against historical, political-economic and social forces that foreclose life chances for well-being.⁹³ In other words, it is multiply unjust that they should endure such raw deals with such little recognition of their ongoing suffering as well as their well-intentioned attempts at self-care.

The Rhetorical Turn to “Trauma Talk” In Massachusetts Prisons

Yet maybe the lack of recognition of trauma among addicted and incarcerated women was changing. In 1997, the Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored a unique, five-year, multi-sited study called the Women, Co-Occurring Disorders and Violence Study (McHugo et al. 2005; Clark and Power 2005). This project was unique in its design: the first two years of the study were dedicated to bringing together trauma researchers, people with lived experiences of trauma, direct service providers and organizations concerned with trauma to discuss what an ideal service provision models might look like. In the

⁹³ Memoirist Asha Bandele writes, “For a time all I thought about was what would a never-molested asha look like? That question stuttered my movements, my breath, and my sight. Would I have gotten a Bachelor’s Degree in four years instead of fourteen? Would I have walked away from drugs? Would I be able to drive? Would I like my body? Would I have been able to say no to the food, the drugs, the alcohol, the abusive men, and all the years of hysteria and depression? Would I never have had the persistent and crippling sense that I was dirty, a whore, a funky bitch, not good enough, an undesirable” (1999: 97)?

next phase of the study, nine sites developed these trauma-informed service interventions that attempted to integrate trauma, mental health and substance use treatment. The study showed, not surprisingly, that the women and their children who received these interventions had significantly more positive outcomes than those who received services as usual (Markoff and Finkelstein 2002; Morrissey, Ellis, et al. 2005; Morrissey, Jackson, et al. 2005).

The SAMHSA study did much to raise awareness about the effects and lasting impacts of trauma on women and children in mental health and addiction treatment communities. In Massachusetts, the Institute for Health and Recovery (IHR), based out of Cambridge, was one of nine national sites selected to implement the trauma-informed service interventions. As a result of their work with community partners across the state, there was growing awareness of the importance and centrality of trauma to all ongoing treatment work and service provision.

At the same time as this increased awareness of trauma was occurring across treatment providers in Massachusetts, the prisons were dealing with scandal yet again after the murder of a high-profile inmate and former Catholic priest, John Geoghan, while he was in Department of Corrections (DOC) custody.⁹⁴ Then governor Mitt Romney ordered a review of eighteen areas of specific investigation throughout the state prison system; one of these areas included the state of women in prison. This resulted in a year-long investigation and a subsequent “Dedicated External Female Offender Review” (Dennehy 2005).

The notion of female difference ran throughout the review. Women were implicitly and explicitly compared to men: “They have gender specific issues that significantly impact their

⁹⁴ John Geoghan was a priest who was symbolic of the Boston Roman Catholic sexual abuse scandal. He was accused of sexually abusing more than 130 children over his thirty years as a Boston-area priest. While he was incarcerated in protective custody at MCI-Shirley, one of the medium security men’s prisons in Massachusetts, his cell-mate, who was serving a life sentence without the possibility of parole, murdered him. After this high profile incident, the Department of Corrections underwent many reviews of the prison system as it came under increased scrutiny (see (The Geoghan Case/Boston Globe Staff 2002; Farragher 2003).

potential for successful reentry,” the commission authors wrote (as if men did not have gender specific issues).⁹⁵ Their report noted that women in Massachusetts were sent far away from their home communities to serve their sentences, since there were much fewer DOC facilities for women than for men. This had a detrimental effect for the purposes of “re-entry” since families were less likely to visit and remain connected with incarcerated women. The commission authors also noted inadequate screening for treatment of mental illness as well as medical issues.

Trauma was a central organizing theme of Commissioner Kathleen Dennehy’s report. Among one of the “gender-specific medical needs of female offender population,” one of the “major findings” was the fact that the “majority of female offenders have trauma-related histories that negatively impact their health status and their successful utilization of health care services” (Dennehy 2005: 4). It appeared throughout sections that were not, at first glance, relevant to trauma, as well as had its own separate section devoted to addressing trauma. There was a general acknowledgment among the commission that trauma was a serious concern for the Department of Corrections when working with “female offenders.”⁹⁶

The recommendations of the commission were to train staff and change protocols to “assure that they are trauma-informed and well-integrated.”⁹⁷ The ‘trauma’-related subgroup found that “consistent with the literature, MCI Framingham staff estimates that 90% of women receiving mental health services at MCIF have identified trauma histories” and that “substance

⁹⁵ Trauma is often used as a stand-in for what makes women’s experiences “different” than men. Trauma is often synonymously used to stand in for ‘gender-informed’ or the experiences of women more generally. This is an unfortunate and imprecise enmeshment of terminology.

⁹⁶ There is good evidence that a “trauma-informed” lens would also benefit men who are incarcerated as well; studies on men who have been incarcerated reveal that these men as a sub-population have disproportionately experienced or witnessed physical or sexual abuse as well as violence (Covington, Griffin, and Dauer 2011).

⁹⁷ “Trauma-informed” services, are defined as a system “in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence plays in the lives of adults, children and adolescents and families or caregivers seeking mental health and addiction services.” These systems should be designed or redesigned to “accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will avoid inadvertent retraumatization and will facilitate consumer participation in treatment” (Jennings 2008: 10; see also Maxine and Fallot 2001).

abuse staff report similar prevalence of trauma among female offenders receiving substance abuse services at MCIF” (Dennehy 2005: 61). The authors of the report wrote that

the absence of a trauma-informed environment and truly integrated health, mental health, substance abuse, and other support, puts women offenders at risk of under-utilization of needed health-related services, reduced benefit from services accessed, potential re-traumatization, and increased recidivism and behavioral and health risk upon return to the community (ibid).

The trauma focus group recommended a change in the prison “ecology” of the “systems of care within Framingham” (Dennehy 2005: 61). This meant more coordination across the various sectors of the prison (since various medical and social services had been contracted out a variety of vendors) to address trauma from a more streamlined approach. The commission also thought it was important to create a separate funding stream to address trauma within the prison and to have dedicated external review of changes in policies and protocols (these never occurred).

There was also some, albeit limited, recognition of “re-traumatization exacerbated by lack of access to effective family and community networks connections” (Dennehy 2005: 60). It was easy to blame the distance of housing inmates far from their communities for such “re-traumatization” but it was not easy for the commission to acknowledge the prison as a traumatic experience in and of itself. After all, that would be acknowledging that prison’s punitive environment was intentionally traumatizing, intended to punish women for their crimes and instill a fear of incarceration that would deter future criminal activity.

Trauma (Treatment) in Practice: (Discipline-Punish)-"Manage-Care-Program-Prepare"

Mission Statement: The Massachusetts Department of Correction's mission is to promote public safety by managing offenders while providing care and appropriate programming in preparation for successful reentry into the community. Manage - Care - Program -Prepare

Vision Statement: The Massachusetts Department of Correction's vision is to effect positive behavioral change in order to eliminate violence, victimization and recidivism.

In 2013, trauma is officially on-board at both the state women's prison and the local Boston jail. Both institutions have had to shake some of the more unsavory events of the recent past; they both now vigorously emphasize the ongoing “programming” opportunities for women as well as changes in leadership and rigorous trainings of staff. Re-visiting the recent past is critical, though, since it situates the current trauma work in the context of a troubled legacy and problems intrinsic to the process of incarceration itself.

Boston has two local jails, the Suffolk House of Correction and the Nashua Street Jail.⁹⁸ The Nashua Street Jail was built to replace the historic Charles Street Jail that had operated since 1851 and was ordered closed in 1973 by a federal judge. The Nashua Street facility opened in 1990 and has capacity for approximately 700 people awaiting trials. Suffolk County House of Correction (also known colloquially as South Bay) was opened in 1991 to replace the aging Deer Island facility (a jail facility located in the Boston Harbor) and has capacity to hold 1250 inmates (but has housed as many as 1900).⁹⁹ The South Bay facility is equipped to incarcerate both pre-trial detainees as well as men and women who have been sentenced to time less than two and a half years (otherwise, he or she would be transported to a state facility; in the case of the women, all of them go to MCI-Framingham). It is also the facility that detains individuals with Immigration and Customs Enforcement (ICE) violations.

Both Nashua Street and Suffolk County House of Correction suffered from scandals within the first decade these facilities were open under the leadership of the Sheriff Richard

⁹⁸ In Massachusetts, there is a three-tiered system of detention: jails, Houses of Corrections, and prisons. Caleb Smith, in his cultural history of incarceration in America, writes that in the 17th century, “Reformers conceived of the ‘Houses of Corrections,’ a secluded institution of chastisement and training from which, in time, a remade citizen-subject would emerge into the social world. It was Benjamin Rush who wrote that the redeemed convict would be greeted as one who ‘was lost and is found—was dead and is alive’” (2009:10). Benjamin Rush, a Philadelphia-based physician and an ardent prison reformer, was an early advocate of Houses of Correction.

⁹⁹ Donald K. Stern, former US attorney general, in an independent report ordered by the Governor of Massachusetts regarding allegations of abuse and political corruption at the Suffolk House of Corrections, wrote of the predecessor institutions that “both the Charles Street Jail and the Deer Island Penal Colony shared a history marked by instances of political scandal, riots, escapes, overcrowding, brutality, and court-ordered reform” (Stern et al. 2002:1).

Rouse.¹⁰⁰ At Nashua Street, a young woman named Katrina Mack came forward about being strip-searched after being arrested after driving under the influence while she was held overnight at the facility. On behalf of 5400 women who had passed through the Nashua Street facility between 1995 and 1999, Mack sued Suffolk County, Sheriff Rouse, a female correctional officer, and the City of Boston, for her and others' injuries caused by unconstitutional strip searches, a violation against their Fourth Amendment rights prohibiting "unreasonable searches." Suffolk County at the time had a policy that stated that "strip searches shall be conducted of all inmates committed to the custody of the Department," including both a visual body cavity inspection of the anus and vagina. It furthermore became clear that the men who were similarly detained after being arrested were "not subject to such searches as a matter of routine" (Mack V. Suffolk County 2002:2). This was because men were held overnight at local Boston Police stations while women were transferred routinely to Nashua Street.

Federal Judge Nancy Gertner ruled that the City of Boston and Suffolk County were guilty of violating the civil rights of these women and ordered restitution in the form of \$5 million each from both the City of Boston and Suffolk County; the City of Boston paid in 2002, the Suffolk County Department of Corrections received \$2 million appropriation from the State

¹⁰⁰ Richard Rouse, an appointee of the then-Republican governor, William Weld, had no experience in corrections or in running a \$90 million department and was Sheriff of the Suffolk House of Corrections from 1996 until he resigned in 2001 as part of a buy-out from the county. The *Boston Globe* published an investigatory piece detailing the alleged corruption and insider appointments under Rouse. They also follow him for several days and observed he maintained a four-hour work-day as well as switched license plates on his state work vehicle in order to drive his children to and from school and soccer games (see (Murphy and Rezendes 2001). The acting governor Jane Swift appointed a former US attorney general, Donald Stern, to lead an independent investigation into reports of abuse and corruption at the Suffolk House of Corrections later that year; Stern had indicted seven Suffolk County prison guards on brutality charges earlier in 2001 ((Phillips and Latour 2001). Stern's report detailed a "deeply troubled institution, where conditions were ripe for officers so inclined to abuse their authority" (2002: 8) with the presence of many abuses, unsafe conditions and drugs. The Commission deemed a new 300-bed-facility at Suffolk House of Corrections that was initially constructed to hold the female population as "an inappropriate design" that "may make it difficult to prevent the types of sexual misconduct that have been encountered in the past" (Stern et al. 2002: 26).

Legislature after it could not raise the money (Tompkins 2004). The policy on strip searches was changed after the settlement to only allow strip-searches of women if there was probable cause.

Tina, whom I had met in the suboxone clinic, was one of the 5400 women who was strip-searched at the time. She vividly remembers the attorney, Howard Friedman, as he advocated for all the women. She had been strip searched at least ten times during those years; Nashua Street was a familiar place to her during her estimated thirty lifetime incarcerations. She felt that the strip searches were insult on top of injury, a constantly humiliating attack on well-being.

As a result of the Nashua Street scandal, women were no longer detained there; instead, they were all held at the \$115 million modernized county facility at South Bay in Newmarket Square just off I-93 near Boston Medical Center. It perhaps was not a safer or better place for women to be. Almost concurrently as the Nashua Street civil lawsuit was being filed, a woman alleged that she had been sexually abused by a prison officer named David Mojica while she detained at Suffolk House of Corrections (Latour and Farragher 2001).¹⁰¹ There was evidence that there was rampant sexual activity and corruption among the guards and healthcare staff (an allegation was made against one of the male nurses). Inmates in sexual relationships with the guards could leave the cells and eat take-out Chinese food or obtain heroin from officers who would transport it for them from male inmates also housed in the facility. One inmate was quoted in the article saying "if you had long hair and a decent body at South Bay, you had it made"

¹⁰¹ In September 2013, Mojica was arrested in a nine-month gang sweep operation called "Operation Dethrone II" in Chelsea, Massachusetts conducted by the United States Attorney General and the Suffolk County Attorney General, along with the New England FBI and State Police, for involvement in drug and firearm running in the street organization, the Almighty Latin King/Queen Nation Street Gang, also known as the "Latin Kings." Chelsea Police Chief Garvin was quoted in a press release saying, "Drugs are devastating our city. We will not stand by and let gangs and drug dealers operate within our neighborhoods with impunity. As this investigation proves, we are committed to working with our federal and state partners to remove drug dealers from our streets as fast and as long as possible." According to the indictment, Mojica, whose nickname was "House," "is alleged to be a former Suffolk County Sheriff." He was charged with "conspiracy to distribute at least 5 grams of cocaine base and distribution of at least 5 grams of cocaine base" See press release, "Eighteen Members of Almighty Latin King/Queen Nation Named in Federal, State Charges (FBI Boston Field Office 2013).

(Latour and Farragher 2001: N.P.). The former director of mental health services at the jail, Dr. Eric Brown, said that "for the women who have sexual relations with guards it would get them out of their cell"; when Brown found out about these sexual encounters between inmates and staff, he informed the Superintendent John Twomey who told him, "This can't get out. We're going to take care of it." Twomey demanded the names of involved women from Brown, who refused to give them citing patient-doctor confidentiality, and the investigation remained internal.

Understanding the relatively recent history of scandals at the local House of Corrections and jail is critical to getting a sense of the kind of "places" that prisons and jails are: they are marked by lack of freedom and abuses of power are commonplace. It is the very architecture, process and goals of prisons that make them invariably a place of ongoing danger, coercion and anguish.

The deprivations of liberty caused by incarceration can lead to predictable consequences that stem from the lack of freedoms. These range from engaging in survival sex inside with the prison guards to enduring individual mental anguish or somatic symptoms of distress. The prison readies itself for potential flares of prior PTSD and also new occurrences; as one woman involved in mental health operations at the prison told me, "A lot of that stuff [trauma] can certainly be exacerbated in a penal environment... any correctional institution is going to trigger people who are more vulnerable to PTSD just by the nature of the environment, so we expect a lot of that to surface." So the mental health team actively seeks to work against unearthing trauma and minimizing damage caused by the traumas of becoming incarceration, or what they call "adjustment" to prison life.

Prison mental health staff are triaging from the start based on a nursing evaluation conducted of all women who enter the facility within 24 hours; they cannot treat everyone equally, carefully assessing women's "risks" and "needs," particularly on the look-out for women with previous suicide attempts or self-injurious behavior. These women pose a special "risk" to themselves (as well as to the facility's image as a safe, caring and rehabilitative space) if they manage to seriously injure or kill themselves. The prisons have learned this the hard way. Most recently, several women have hung themselves at MCI-Framingham and died and two more had tried to hang themselves in 2009 and 2010 (Huggins 2010; McDonald 2009). At the time of these deaths, two mental health positions had just been cut and two unfilled positions were also eliminated from MCI-Framingham's mental health staff.¹⁰² Upon hearing of the three suicide attempts, State Representative Kay Khan admitted, "In a way, it's a psychiatric hospital" (McDonald 2009).

Because prisons are playing "defensive" against potential suicides, the majority of the women entering prison suffer from the benign neglect of the triage process. With not enough resources and staff, the prison mental health staff attempts to see all women admitted to the prison within 14 days of arrival. Part of the questionnaire completed by the nurse in the first 24 hours is a list of psychiatric medications that a woman might be taking in the community (many don't even know exactly what they are prescribed). The staff attempts to verify these medications by calling MassHealth as well as prescribing physicians and pharmacies. If the medicines can be verified, they are sent to a psychiatrist for review; it is up the individual

¹⁰² Prisons and jails have suffered from the deinstitutionalization and closure of state mental health hospitals and the subsequently underfunded, fragmented and inadequate community-based mental health services. Tom Dart, the Sheriff of Cook County Jail, the second largest jail in the United States that has a standing population of over 10,000 incarcerated people, recently stated that jails were "the new insane asylums" and he has previously considered suing the state of Illinois for making the jail a "dumping ground" for mentally ill people (Kristof 2014). Here in Massachusetts prisons, there is a suicide rate of 71 per 100,000, which is four times higher than the national average of 16 per 100,000 people (Saltzman 2010).

psychiatrist's level of comfort with the specific medications to prescribe a "bridge" prescription or not. For those women whose medicines cannot be verified, they are not triaged or assessed in any special way by mental health: "They wouldn't automatically be seen by psychiatry unless clinically indicated, so we would see them for mental health treatment and [if] determined that psychiatry was indicated, we would refer and they can see them."

Thus, the fragmentation and disruption of care caused by institutionalization continues in the form of prolonged lack of access to community-prescribed psychiatric medications, causing disruptions that can affect women's already labile or fragile mental states upon coming to prison. The prison mental health program says that they offer a variety of treatment programs for all women—a mini-hospital of sorts:

At Framingham we function as sort of a little community, so if you think about all the mental health services around the community and sort of anything from case management to outpatient therapy or outpatient group therapy to outpatient or partial hospitalization to inpatient hospitalization stabilization, emergency room visits, we basically have all of that in here. So we are able to determine kind of what level of care somebody needs.

One-on-one counseling tends to be rare, while group counseling is much more common and cheaply provided. One of the trauma-focused groups at MCI-Framingham is the “Victims of Violence” class run by the in-house drug treatment vendor, Spectrum Health Services, that teaches a widely regarded curriculum called *Seeking Safety* written by Lisa Najavits, a trauma researcher at McLean Hospital/Boston University.¹⁰³ The class is called "Victims of Violence" at the prison in order to show that it is providing programming on a wide variety of kinds of violence and exposures to violence in order to fulfill state and national audit criteria.

¹⁰³ Najavits writes of *Seeking Safety* that “one program initially called their group “Trauma Group” and few clients wanted to attend. When they renamed it “Seeking Safety Group” the attendance improved considerably. If the group titles includes the term “trauma” or “PTSD,” clients may fear that they will be asked to describe their traumas or will have to listen to others do so, and may not feel ready for that. If it has a more upbeat title, they feel more reassured” (Najavits 2002b).

"Safety" became a popular buzzword in trauma treatment after the publication of psychiatrist Judith Herman's influential treatise on trauma (Herman 1992). In *Trauma and Recovery*, Herman argued that there were three stages of trauma treatment: 1) Safety, 2) Mourning (trauma processing) and 3) Reconnection. Najavits named her program *Seeking Safety* to represent "Stage 1" work to specifically treat co-occurring PTSD and substance use.¹⁰⁴ Najavits described the main goal of the program as establishing a sense of safety first and foremost:

When a person suffers from both substance abuse and PTSD, the most urgent clinical need is to establish safety. Safety is an umbrella term that includes discontinuing substance use; reducing suicidal and self-harm behaviors such as cutting; minimizing HIV exposure; ending dangerous relationships, such as with abusive partners and drug-using friends; and gaining control over extreme symptoms such as dissociation, or "spacing out" (Najavits 2002b: 136).

The concrete goals of the treatment program were "abstinence from substances and personal safety" (Zlotnick et al. 2003: 100). Along with colleagues at Brown University, Najavits assessed the effectiveness of the *Seeking Safety* curriculum in a small pilot based at a women's prison. They concluded that the treatment was a promising intervention for incarcerated women with PTSD and substance use disorders because it targeted "many of the deficits found in this population that may interfere with their recovery and place these women at risk for reoffending, such as impulsiveness, anger dyscontrol, and maladaptive life activities" (ibid).

This program particularly appealed to the prison treatment environment in which the deficits of women's thoughts and behaviors were the main target of intervention. But there was an emphasis on hope and the importance of instilling and cultivating lofty ideals that female prison reformers had historically espoused. The 25 topic areas sought "to instill humanistic

¹⁰⁴ According to the *Seeking Safety* manual, it is important to recognize the link between PTSD and substance use and to treat them concurrently. Najavits writes that "the relationship between PTSD and substance use is complex. Using substances can either increase or decrease PTSD symptoms. Yet abstinence from substances can also increase or decrease the PTSD symptoms." She goes on: "The 'big picture' priorities in this treatment are: Eliminate substance use, learn to manage PTSD, become safe!" (2002: 119).

themes to restore patients' hope for a better future" since "especially in combination [PTSD and substance use] lead to such demoralization and loss of ideals" (Najavits 2002: 137-138). There was a special emphasis on positive attributes and forward-thinking language that "emphasizes values such as respect, care, integration, and healing" (Najavits 2002: 138).

Yet none of the women in my small sample of approximately ten women from MCI-Framingham and the South Middlesex Correctional Center pre-release facility had chosen to take the *Seeking Safety* class, which speaks to the self-section involved in choosing to even take the class in the first place. These women that I met in prison felt that the prison was not a "safe" space for them generally to undergo mental health treatment although they spoke of general desires to be in treatment and to heal from past traumas. Maybe some of them sensed that the prison was, by its very nature, antithetical to achieving the goals of *Seeking Safety*. Linda, a 50-year-old African American woman who has dealt with over 30 years of heroin addiction, told me that when she was MCI-Framingham, she didn't "choose to share anything with my case worker." She elaborated, "I wasn't ready to deal with trauma, I had a nasty attitude and didn't want to be bothered. I wanted to do my time and get up out of there. Being in the system as many times as I have, you have some workers that really do care about their clientele and you have people that don't. I want to deal on my own time with real, professional people [in the community] not these people that MCI-Framingham had working for them."

To put it simply, what is the point of speaking about such things in the prison? In both the male and female units in the jail, participating in therapeutic talk can be dangerous: Revealing one's feelings, one backgrounds, why one uses drugs, what one has lived through and endured on the streets and otherwise—all of these things can place someone at risk of being preyed upon, emotionally, physically, sexually or otherwise. One woman, Catherine, told me that

if “you break down and cry in here, you just become a target for everybody else. Your weakness.” Becoming a target includes being preyed upon, taunted and bullied. It highly increases the risk that one will have to fight or endure harassment. Therapeutic talk, in other words, can be highly dangerous in a prison environment.

One staff member at the South Middlesex Correctional Center, the unlocked, minimum security pre-release facility for the women located just "across the street" from MCI-Framingham, told me that Framingham didn't do trauma treatment because "they have enough [suicide] attempts as is." She said that they didn't have much discussion of trauma at South Middlesex Correctional Center as well, because they didn't have 24-hour mental health staff and the facility was "too open," that is, there was too much risk of unearthing trauma and being unable to handle the potential consequences. Doing trauma treatment, therefore, meant taking the risk that a person might attempt something desperate if feelings and memories were unearthed and difficult to control. These risks are generally deemed intolerable for prison administrators, who are responsible for constructing and maintaining the public's perception of prisons as providing a safe environment and doing the work of rehabilitation. The public's perception of the prison as efficacious is critical to its very existence. As Foucault has written, "The law must appear to be a necessity of things, and power must act while concealing itself beneath the gentle force of nature" (1995: 106).

Not surprisingly, the women I interviewed did not report any resolution to the past traumas in their lives. Many of them had attempted therapy in the community but had been scared away by intense feelings and memories and instead retreated in substances. One woman told me aptly, "Once I'm using [drugs] I feel kind of like I don't want to go to a counselor. Like,

this is my counselor." They also feel like ongoing traumas continued to be unaddressed in both the prison environment and the community after release.

It is clear that if trauma is addressed as a part of drug treatment or any other kind of programs at the prison, it is haphazard and random at best, contingent upon individual counselors or instructors and his or her level of comfort teaching or discussing trauma. While the drug treatment services at MCI-Framingham are contracted out to Spectrum, the mental health services are contracted out to the MHM, a private, for-profit, prison mental health services vendor based out of the state of Virginia. Some programs are run by the Department of Corrections itself and its internal staff. The trauma services, therefore, end up in practice as haphazard or random.

The prison staff and experts on trauma state that the prison is not a safe place to address trauma; as Najavits writes, "Correctional settings, in particular, may be unsafe, as inmates may be destabilized by such treatment" (2002: 137). Yet the prison wants to appropriate trauma as part of its efforts to "manage-program-care-prepare" inmates but only in a limited sense: the recognition of trauma symptoms and carefully delimited management. Inevitably, though, stories of past traumas slip through by inmates who are desirous of healing. Tina tells me a story about "life maps" at her drug treatment class where "a lot of girls wanted to talk about what it was like doing drugs while they were pregnant" and what it was like being raped or engaging in survival sex for drugs. They wanted to process their traumas, an understandable occurrence as they draw on memories to make meaning in the present and for the future.

But what is the use of learning about trauma and coping skills in prison only to be released back into pathological or dangerous environments in which violence, drug use and certain kinds of relationships otherwise deemed harmful can actually be protective in the short-term? How can the goal of establishing a sense of safety be taken seriously in the context of a penal

environment, where punishment and discipline are the main goals? ¹⁰⁵ In one of my interviews at MCI-Framingham, I asked about a woman's anxiety and PTSD. She told me, "I don't really want to get into this now, because I'm just going to have to go back to my unit... I don't want to fuck up [behave badly, like fight or act out]. On the outside, you have support, in here, you really don't have anybody you can lean on."

Psychoeducation: Mental Health and Trauma Treatment at the Suffolk House of Correction

"I've been here a year and I haven't gotten in one fight. That says a lot." -Shari, 32-years-old, incarcerated at the Suffolk House of Correction, Boston, Massachusetts

Shari is a baby-faced 32-year-old African-American woman who looks like a teenager with plump cheeks and smooth, unlined skin. I meet her when she is incarcerated at Suffolk House of Corrections awaiting trial. She has been involved in a complicated court process that means she has been incarcerated as a detainee for a little over a year. Shari tells me a little bit about herself. She was born in Dorchester and grew up on Blue Hill Ave near Franklin Park. Her mother abused her verbally and physically, and her father was generally absent. She learned later that she was one the oldest of ten children he had fathered. Her mother was "addicted to drugs [crack, alcohol, weed] at a fairly young age," and Shari thinks that her mother didn't have "the proper mental health treatment, the proper coping skills, appropriate coping skills, parenting classes." Her mother never could hold down a stable job; at her best, she worked for five years at a publishing company. Her father was in the Army: "I remember he went to Kuwait and he brought me back a t-shirt with his name on it. He wasn't addicted to drugs [crack cocaine] at the

¹⁰⁵ Denise Elliott and her colleagues write of the discrepancies in rhetoric and practice implementation of "trauma-informed" services. One principle they highlight as essential is the need for "trauma-informed services [to] create an atmosphere that is respectful of survivors' need for safety, respect and acceptance" (See Elliott et al. 2005, 467). This is, in many ways, the very opposite of prison environments.

time, it wasn't until the second time he came back." After a life in and out of foster care and selling drugs in Ashmont Station in Dorchester, Shari ended up moving to Washington D.C. after breaking up with her ex-fiancé. She tells me some of the details:

Shari: We moved in [together] and we were going to get married and have kids and all this stuff, and then I caught him cheating on me with this girl he was with before. I caught a [criminal] case behind this chick.

Kim: You fought her?

Shari: I was trying to. I had her locked in the house for three hours. And she wouldn't come out. "You want to fuck my man but you don't want to get your ass whooped?" I don't get that. If you beat me up, I don't care, but we're going to fight, and you can have him after that. Even if you beat me up or not, I'll leave y'all alone... Come on, you know that he's with me, and he claims to be with me, and I beat him up too. Then they called the police on me, I got a charge, and I left, and I was like whatever.

Kim: What'd you get? Assault and battery?

Shari: I didn't get arrested for that because they didn't show up to court. And then I was like, you know what, I'm moving to DC. I had to move out of state, because if I don't, I'm going to hurt them.

Shari ended up in Washington D.C. because she originally met a "pimp dude" in Ashmont Station while she was selling weed. She never thought of herself as that kind of lady: "I'm a drug dealer, I'm known for that. I associate myself with drug dealers... I don't respect hos." She saw a man approach a woman trying to get her to "turn tricks" for him. Going up to defend the other girl, Shari hit it off with the pimp, and she agreed to his offer of "800 dollars to do what you have to do and I just help you out and you help me out" even though she defines herself as mainly a drug dealer: "I'm just not that type of chick, no disrespect to you or anything. I rob guys, I sell drugs and shit like that, I'm not selling my pussy for you, not for nothing."

She tells me that she didn't even have an excuse when she started prostituting; she wasn't addicted to drugs yet, she was "straight sober." She and the pimp began to travel, to New York City, Atlantic City, and finally D.C. After a while, she became scared of him:

He beat the shit out of this other girl. I thought somebody was like breaking in our house, you know, our hotel room, robbing us or something. Maybe, I didn't know what the hell was going on. So I crept up the stairs, and I seen this girl, and I heard the fricking punch like boom [makes punching sound], and I'm like maybe he's fighting this dude, maybe he had to beat this dude for doing something to her, and like, he

hits this girl. And she's like your size and he's fucking huge. I'm like, oh my god, my ex-fiance was abusive to me, and I loved him. I don't know you, and if you're abusive to me, you could kill me. I'm like oh my God, I'm like all right... I just came back to chill and the room was a mess it was crazy. She's like fuck this I'm not making any money, I'm calling my sugar daddy at home telling me to wire me money. I'm like all right, so I just stayed out the whole fucking night, we left and went to DC and I'm like losing my mind.

Then that night went good, the night after that we weren't making any money. It was 6:00 in the morning... he's calling, how come you guys aren't making any money out there? And I'm like, oh my God, he's going to like hurt us. And then he called me to come back and have sex with him, and I'm like oh my God. I told him I am not going to sleep with him. Maybe if I don't have sex with him he's going to do something. So I had sex with him, [and while] he's asleep I took all the fucking money he had, all that money and I left with the dude that I was getting high with. I'm like, yeah he's asking me to have sex with him. I was like I can't go back there and get my stuff. That stuff is gone. He's going to kill me, and he's going to know I'm leaving, he's going to fucking try to hurt me.

This is only a small part of Shari's complicated life (when she returns to Boston, she has two children by different men and begins a relationship with a rich white man who tries to save her from her life as an Internet prostitute; she gets married to a man who is not the father of either of her children and who has tried to "stab me ... in my own house").

When we meet in jail, Shari is actively working through the concept of trauma and understanding her mental health issues. She has it on her mind, and is eager to talk it all out with me. Her words come out in a whirlwind and it is difficult to even follow her many intertwined lines of thinking. She tells me about how she got diagnosed with PTSD while incarcerated at MCI-Framingham awaiting trial:

Shari: I guess I've endured a lot of trauma, and it's like, with PTSD, with any psychological diagnosis, the woman [mental health counselor] is really good there. She's like, you need to be educated on what you have so that you can talk about it. I knew I have anxiety, I knew I was irritated, but I couldn't understand why. So taking this class at Framingham made me understand what's going on with me, in that I'm irritated and anxious at people when the littlest thing happened. It's just not that little thing to me, it's the big thing that happened twenty days before that, and the little thing sets me off. I can't just stay with that one thing. So I'm coping with that, I'm learning coping skills.

Kim: What was the name of the class?

Shari: DBT.

Kim: Oh, dialectical behavioral therapy?

Shari: I forgot the other name of the class we took before that. But I couldn't even deal with it. It was just really hard for me, really really hard for me to sit and express and get deep, deep into me, because I got frustrated.

The mental health team at the Suffolk House of Corrections, like their counterparts at the MCI-Framingham, sees the goals of their work with detained and sentenced women as primarily stabilization and psycho-education. Shari is a perfect example; the staff at the jail does psycho-education with Shari, giving her the language to "understand what's going on with [her]." Doing psycho-education work in a carceral environment entails teaching women how to identify their emotions and their inner mental states, linking it with consequent substance use and coping skills, and identifying all of these as psychopathological. Yet doing further "treatment" or trauma processes (stage two and three work, in treatment terminology) in carceral settings is frowned up as bad practice since the jail and the prison are such de-stabilizing environments; as Laurie Markoff, a trauma integration specialist at IHR, told me, "For people in prison, it's not the time for them to be going in-depth in their stories, it's not a safe environment."

For the staff at the jail, they feel they are constantly working at a time disadvantage as they try to keep up with the movement in and out of the jail. They must deal with a rapidly transient population; a woman might be here one day, receiving services and medications, and the next day, gone. If a woman has court in a week, she could be released from court that very day to the streets, be sentenced and sent to MCI-Framingham or moved into the sentenced women's unit, or be held waiting for another court date in the jail. Thus, trying to assess and treat the psychiatric and mental health needs of such a transient population is challenging. To provide programming and mental health continuity of care back into the community for a large number of women is an arduous task and one that has limited success.

Thus, the psycho-educational piece feels like something feasible. To the staff, it feels like impactful work that can positively benefit incarcerated women's subjectivities by allowing them to both name and re-shape their life stories. One of the staff mental health clinicians at the jail told me that engaging in "psycho-education" was what was most rewarding for her in her daily work. She tells me, "You know, I've had women say, my mind is drifting off and I don't understand what's happening... I say, well, you know, this could be connected to things you've said you've been through. Some of them are just not, don't have the education about it. I'd say the psychoeducation can affect people [positively] sometimes."¹⁰⁶

At the same time that it feels rewarding to mental health staff to educate impoverished women with life histories of neglect, abuse and suffering about PTSD, there are unclear, perhaps unintended consequences, of doing so. In Shari's case, she was hesitant to engage in treatment, largely relate to guilt over not being present in the community to raise her children:

I think [this mental health treatment] is something that I want to continue, I think it's something that I need to make a part of my life. It's something that I am stuck with for the rest of my life, and I really have to take care of that. It's my responsibility to get up every day and address that issue. I have kids. So when my kids do something that makes me upset, I can easily go into a fit and rage, and that's not how I am, I love my kids, I take care of my kids and I provide for them, I don't complain about taking care of them... So it's very frustrating for me to have to step back and take the time away from her [my daughter] so that I can fix me, and that's something I wouldn't be able to do on my own, and being incarcerated is allowing me to do that, unfortunately, because of society too, it's my responsibility to take care of my children. I'm not going to say, you take care of my kids so I can go get help, that's not how I was raised.

Shari points out that if not for her forced confinement, her incarceration, that she probably would not spend any time getting treatment in the community for her mental health issues. She feels conflicted about having children in the first place and being burdened with the

¹⁰⁶ She gives the example of a woman who was present at the Boston Marathon bombings in April and becomes incarcerated at the jail: "Working with her in the immediate aftermath of that, and just educating her about the symptoms that you're seeing, they're pretty common, and you can probably expect them to get better with time. This is what you may see happen. And she did in fact see that nightmares and the hypersensitivity and stuff was declining over time, and I think it helped her to just have some education about what she might see happen over time."

responsibility of being their caretaker, but she also feels glad that having children forced her to "acknowledge that I even have a problem." The mental health staff at the jail have taught her how to construct and re-narrativize her life around the trope of trauma: "What am I supposed to do? The trauma is coming there. That's where we get into trauma, because I start thinking of my life and every time something happens when I'm met with an obstacle, it immediately jumps back."

She insists that when she is released she wants to take care of her children and work to support them in line with the American ideal of independence and hard work: "This [being incarcerated] maybe will allow me to fulfill my expectations as their mother and an individual person. I can go to work and do what I can for my children... But I don't want my kids to be sucked into an unhealthy environment because of my mental health issues."

Part of her mental health treatment--for diagnoses she has been given in prison of being "borderline bipolar," having "post traumatic stress disorder," and a history of "post partum [depression]"—has been medication. The jail psychiatrist gives her different medications to try, including fluoxetine (Prozac), sertraline (Zoloft,) valproic acid (Depakote) and possibly tramadol. As she tells me:

I took Prozac and they upped my dosage and then I started taking Depakote and then I just got to a point where I felt stable and I didn't take it. I feel fine, feel like I've accepted, I feel like I've come to terms with a lot. I feel like the only thing, I was explaining to the therapist, the psychiatrist yesterday, I'm peaceful naturally, you know. We're having a conversation right now, [but] if one of the officers came in here and was completely rude and disrespectful about us terminating [this interview], that would irritate me to the extreme, and my natural reaction would be to cuss them out. But I'm able to take that split second to think about it, but it would affect me, more than it probably would affect you, you know what I mean? And what is that called. How do I address that, how do I deal with that, they're telling me that I have to take medication everyday for something, for some way that I might only feel for two seconds every day?

Like many other people do, Shari feels resistance to the use of psychiatric medications to make her feel calm and stable when her affect dysregulation is only a problem some of the time. Yet it is shocking that she only feels capable of accessing treatment while incarcerated and involuntarily confined, and that only at 32-years-old, after a life of abuse, prostitution and drugs, she can only now "make time" for herself. It is a testament to the levels of chaos in her life as well as the un-coordination and inability of socio-medical institutions to care for her.

A week before this writing, Shari was sentenced at a trial to three to five years at MCI-Framingham. She left the jail and was sent to do her time at the state prison after her conviction. She now has criminal felony convictions for several violent offenses, including attempted murder, though she protests she is innocent, stating that she hadn't left the house that night out of depression, consistent with her pattern of "isolating" and staying at home with her baby son and compounded by her embarrassment that her husband was sleeping around with other women.

I wondered about Shari's fate and how she will make out. I wondered about the trauma work that was done with Shari in the jail, and how that will affect her during her next bid, if at all. Will Shari leave prison more healed and better "managed-cared (for)-programmed-prepared" when she returns to her children after three-to-five years of an interrupted life? I worry that the prison's efforts to raise awareness of her trauma—without sufficient community-supports and attention to the structural sources of violence in her life—will only contribute to ongoing guilt and shame over her separation from her children and a precarious life of economic and existential uncertainty after incarceration.

Coping Skills, Complex Trauma and the Ongoing Violence of the Penal System

Sharon Abramowitz, in her work on psychosocial interventions in post-war Liberia, notes that trauma indicates "a rupture of the self from social and cultural life, to include behavior,

ideas, practice, and relations” (2009: 95). She examines the role of psychosocial counselors working with “people who continue to live lives of exposure to violence, uncertainty, and betrayal [that] require fundamental transformations of self, social relations, and social conditions” (Abramowitz2009: 108). Trauma in Abramowitz’s work represents a social disjuncture and reveals social precariousness; efforts at interventions are more than just individual treatments but also reveal a larger project speaking to belonging and collective memory and healing.

An opposite kind of process of trauma work—one of individualizing, of erasing a collective social status of incarcerated women and survivors of complex trauma—is at play in many of the psychosocial interventions of the prisons. For example, programs like *Seeking Safety* often place an emphasis on what they call “coping skills.” This includes approaches emphasizing meditation and breathing and learning how to identify and regulate one’s troublesome emotional states like anger or frustration or sadness. The instruction in “coping skills” is a means of instilling societal norms regarding the proper “care of the self” (Foucault 1986). The prison treatment programs try to bestow self-care and self-soothing techniques to women who are faulted for their general failures at life, usually marked by an inability to care for themselves. Such an emphasis on coping skills is “present”-focused and tries to teach individuals to deal with their present circumstances; in other words, it disarticulates the inmates from both individual past experiences as well as a collective history of social precariousness that all these women share. This emphasis on the present is important for people with trauma histories in order to prevent a reaction that lingers from past traumas. Laurie Markoff explains:

Sometimes, violence is the right choice for them. One of the things I always say is the issue is to make the safest choice and to have control over the choice. I’m not telling you what to choose...Still, I want you to be making the choice, in response to the here and now, the environment and the risks. Not to what happened to you when you were five. You want to have control and be able to evaluate

the risks and the safety of what is happening now.... As opposed to reacting... Because once you believe that you are in charge, it changes your engagement with everything.

Yet can such an empowering stance take root in people who have no choice over anything, who are contained in small cells and have no choice about what to wear, eat and few choices about where to go and be? It seems a difficult task, one that reflects the impossibility and the irony of treating trauma in a traumatizing place. Mental health staff at Suffolk House of Corrections admit it is a difficult task to teach coping skills; as one case worker said, “This is a very artificial environment. So especially with trauma, a lot of the skills you might be able to use [on the outside]—to get up, get a warm drink, take a walk, things to calm yourself down—these are tools and skills that are not available in here that are available outside. But their outside lives are super chaotic.” Another staff member chimed in, “Like deep breathing and warm drinks even touch any of this stuff [the traumas these women have experienced]. They look at you like, are you crazy? I’m shooting heroin to stop this and you want me to breathe?”

The insistent emphasis on coping, on regaining a sense of autonomy or control in a powerless world, is an important, perhaps noble, goal. But being incarcerated is a disempowering life event and life circumstance no matter what. Learning how to cope better with the daily insults of prison life and life after prison might be critically important in helping women preserve dignity and enable a sense of self-preservation as well as the ability to go on with life. But at the same time, such an approach de-emphasizes the conditions of power and the socioeconomic processes of exclusion and social abandonment that have led to women being in prison in the first place.¹⁰⁷

¹⁰⁷ Even programs that attempt to teach conditions of power and oppression, such as Philadelphia’s Teach Inside Teach Outside (TITO) program, fail if they cannot address the conditions of economic power and the multiple domains of insecurity after incarceration. TITO uses a Paulo Freire-based curriculum to empower individuals in jail and prison to become activists against the conditions that lead to incarceration. But such programs have limited

Both medical and penal systems have become sensitized and aware of the complexity of trauma in women's lives; as Jerome Kroll writes, the medical community has an "increasing appreciation of the complexity, ubiquity, and inescapability of both personal and indirect exposure to trauma and violence" (2003:667). Julian Ford and Christine Courtois, in an edited volume on complex trauma, note that these disorders "go well beyond the classical clinical definition of what is traumatic" (2009: 14) and that "complex trauma poses for the person the internal threat of being unable to self-regulate, self-organize, or draw upon relationships to regain self-integrity" (2009: 17). Complex trauma includes historical trauma of groups; these trauma researchers believe that there is a cumulative nature to trauma for minority groups that are targets for societal violence or endure continuous oppression (Vogt, King and King 2007).¹⁰⁸

Yet is the prison is the right place to heal the complex traumas of women like Shari and Alisha. Shari, a young African-American woman, admitted to feeling isolated, depressed, even dissociative, consistent with complex trauma of a biographical and historical nature. Her core sense of self-integrity was threatened and her behaviors reflected it: she stopped leaving the house, or when she did leave the house, she would get into fights. Without judging whether or not Shari actually committed a crime demanding three-to-five years in prison, I wonder about how community-based mental health treatment could have changed the outcome and the complex calculus of risk and harm that she and others faced. Shari was what clinicians call "treatment-naïve" until she became incarcerated, reflecting both the failure of community-based mental health treatment and the utter complexity and chaos of her life.

success if they cannot address the oppression economic structures that make it difficult to maintain livelihoods as actors (Philippe Bourgois, 02/025/14, personal communication).

¹⁰⁸ Trauma experts actually attempted to propose that complex trauma was a diagnosis in and of itself in the DSM-IV, under the term "disorders of extreme stress not otherwise specified" (DESNOS), although it was subsumed as a variant of post-traumatic stress disorder (see van der Kolk et al. 2005).

“Do You Have Any Enemies?”: Safety, Risk and Trauma Inside and Outside the Prison

The Prison Rape Elimination Act (PREA) was an unfunded mandate passed down by the federal government in April 2012 to address the problem of sexual coercion, manipulation and abuse that occurred in prisons by inmates upon other inmates as well as staff and inmates. After a risk-assessment, including questions like, "Do you have any enemies" (that seeks to identify people who belong to gangs), all individuals coming into the prison are classified as either at risk for being a "predator," a "victim," or neither. The solution, according to the PREA implementation guidelines, was to separate out victims from predators in housing and to "provide meaningful supervision and oversight during an inmate's first 24 hours in jail." PREA consultants noted that women were particularly at risk of assault "(as a percentage of inmates) but they are less likely to report it" (Clem 2012:12).¹⁰⁹

The Suffolk House of Corrections became PREA-compliant after a year of preparations.¹¹⁰ But the PREA mandate is important because it speaks largely to the violence done to people while incarcerated, under the punishment, supervision, and care of the state. Sexual assaults, poor conditions and lack of access to high quality medical and mental health care are only some of what makes the prison a place of ongoing trauma.

¹⁰⁹ See work also by law professors on this subject: Kim Shayo Buchanan, "Engendering Rape," *UCLA Law Review* 2012: 1631-1688; Kim Shayo Buchanan, "Impunity: Sexual Abuse in Women's Prisons," *Harvard Civil Rights-Civil Liberties Law Review* 2007 (42): 45-87; and Heather Moss, "Invisible Aggression, Impossible Assault: Female Inmate-on-Inmate Sexual Assault," *The Georgetown Journal of Gender and the Law* 2009 (X): 979-997, for legal approaches to the prevalence and the nature of female sexual assaults in prisons (Buchanan 2007; Buchanan 2012; Moss 2009).

¹¹⁰ At lunch one day, the case workers are discussing the new PREA screenings. One woman well known to the jail came in the night before and got sentenced to ten days. She fits the profile of a [sexual] predator preying on the weaker ones, they explained to me. She does not see herself that way; she sees it as love, or some kind of mutual desire. The case worker feels sorry for the woman because the woman has been "in the system" for her whole life and is just lost, looking for love in all the wrong ways. The woman had asked to have a "cellie" since she was being housed alone. Apparently, a "predator" can room with another "predator" according to PREA standards. Is being a predator is just another form of misguided intimacy?

Yet for some women, though, the prison can be a brief respite from and resolution to traumatic lives on the outside. Some of the women feel they are arguably safer in prison. Many of these women firmly believe that their lives are saved by incarceration, that being incarcerated is the only thing that would make them stop (not drug treatment, not anything else in the community). So prison can also be a place of safety for some.

For Serenity, a white 43-year-old woman originally from New Hampshire, going to jail was a blessing. "Every time I sit on the church steps getting high, praying to God, just send me to jail... two weeks later, I always end up in jail." When I last saw her before she was incarcerated, she was dating a man named Oscar whom she had met in a residential inpatient drug treatment program. She had convinced him to leave the program with her to get high, and they went off and began living together in the Boston Public Health Commission shelter in Long Island (one of the Boston Harbor Islands that is technically located in Quincy). Eventually, he became convinced she was "making eyes" at other men in the shelter, and he convinced her to stay with him under the I-93 Copley Square bridge. She tells me the story from jail:

Serenity: So we start staying at shelters, and Oscar's mad because there are too many guys there. And there's too many looks. And I should have red-flagged it there. But he's jealous, I'm jealous, no big deal. Okay so now we can't stay at the shelters anymore because there are too many guys there. Now we're staying under the bridge at Copley. And we're walking across the road one day and he grabs me by the back of the head, and pulls my head back to talk in my ear, and he says, "Listen bitch, you keep looking with your fucking eyes I will kill you. I told you before I'm jealous. Don't fuck with me." I'm like, "What the fuck is wrong with you? I wasn't doing anything. I swear to God. I can be a flirt but I swear to God I wasn't. I just let it go. I'm like, yo, I don't know if you need meds that you weren't taking but whatever, you're having a lot of angry outbursts for nothing, Oscar. I didn't do nothing, I wouldn't, I'm not playing with you, we're together."

So I'm sleeping one night down there, we're sleeping under the bridge, whips me over on my back, jumps on my chest and starts choking me, telling me he knows what I'm doing, he knows that I'm trying to make eye contact with the people across the way, and he'll fucking kill me, he doesn't care, he'll go back to prison for over ten years, because in jail he's somebody and out of jail he's nobody. And keep fucking with me bitch. And I'm like in a dead sleep so he makes he get on the other side and sleep facing the other way.

Kim: Were you scared?

Serenity: Very much so. But at this point, I'm like, obviously...with his ex-girlfriend, the things that he had done to her, the reason he didn't kill her is because of the kids, he says. She had kids. And he cared about the kids. Maybe he did, maybe he didn't, whatever. At this point I'm like this man is dangerous, he is dangerous. I just stayed there that night because I felt it might be dangerous for me to try to leave him... and away from everybody too. The next morning he wakes up and he's like, "C'mon we gotta fucking go." I'm just like, "Just give me a minute." He throws his pants in my face, "I don't give a fuck what you do." All right, so we walk out of there and I get up to St Francis [a day shelter in Downtown Crossing] and I told him, Oscar, you told me you don't give a fuck what I did, so leave me alone now. I don't want this anymore. You're too violent, you're scaring me. I need to be alone. "Don't fucking play!" I'm not playing. I want you to leave me alone. And I wouldn't leave the front of the building, because there's police officers and everybody there and he finally left. And I felt like I had to sneak over to my friend's house to stay and not let him know where I am. So I'm kind of intimidated and afraid of when I get out there. I'm kind of afraid of him.

Serenity feels "safe" in jail. She tells me, "I feel calm here. It's crazy. I'm very institutionalized. I'm afraid that if I leave here that I'm just going to be in the spoon by noon [using heroin]." In the jail, she can be freed from her pathological environment, the streets, as well as her own bad decision-making. She relinquishes control and thrives. Her CD4 count goes up, her HIV viral loads go down, all because she actually takes her medication consistently.

The next time I hear about Serenity, the jail administrator tells me that she was released from court to the streets. We all knew there was a high likelihood this would happen—Serenity herself had told me that the judge was going to drop the case because the Commonwealth of Massachusetts had no evidence of a "hand to hand" transaction which they claimed happened in an elevator. Serenity had addressed this issue with her caseworker at the jail; she told me before she left for one of her court dates that she told the correctional officer (CO) that the worst thing that could happen to her was if she was released. She hoped the jail could set her up with a six-month residential drug treatment program.

The staff person at the jail sighed, "It's back to square one with her." In my fieldnote recording this interaction, I am clearly frustrated, writing, "I think about all the possibilities that

could exist for intervening with Serenity: having a community case worker at court with Serenity, knowing the possibility full well existed that she would be released from court, and having someone take her directly to a program or a shelter. At least she wouldn't be off and running. Take her to the Shattuck Hospital where she has her healthcare and a social worker who has known her for years."

Serenity's story indicates the violence of neglect and the violence of release. In Serenity's case, it is vague sense that there is nothing more the jail can do. They must wait for her to become incarcerated again before any more can be done for her. This is violence done unto citizens at the hands of the state in its absence and neglect and it further subjects her to ongoing violence and the everyday traumas of life as a homeless, HIV-positive heroin addict (Bourdieu 1993). Discharge planning is theoretically done for all women to help them access social services, housing, drug treatment, and medical care upon release from jail or prison. In practice, this happens clumsily, if at all. Many women are released on or after their official date if they might have probation or parole or accrued "good time," and coordination between jails and community programs is haphazard at best. This is partly a product of the dizzying turnover and volume of people coming into and out of the prison but also a problem of space and bureaucratic ineptitude and laziness.¹¹¹

¹¹¹ Many times, I had women approach me at the prison wanting to participate in my study. Some would say things like, "Is this about overdoses? I've had many overdoses." One woman, after initially denying that she had used opiates, wrote a note to me via another inmate stating that she actually had used percocets from age 35-38 and that she needed "all the help I can get." Essentially, she wanted to gain access to my study so that she could access services that were essentially discharge planning and were actually not my responsibility, but that of the prison. While I did set up numerous appointments for drug treatment and medical care for women upon their release, their ardent desire to participate in my study was evidence that many women were untouched by the jail and prison's re-entry and case management systems. They did not feel the jail or prisons were responsive to their anxieties about release.

Trauma is everywhere in the prison. The prison is both a perpetrator and receiver of traumas: some insidious, largely invisible traumas related to the lack of care, as well as very concrete threats to one's physical and psychic well-being, such as prison rape or abuse. All of this makes the prison's recent turn to trauma and trauma-related psychoeducation a phenomenon worthy of serious investigation.

Laurie Markoff, the trauma integration expert at IHR, is convinced that the turn to trauma in the prisons is an essentially positive one that humanizes a place marked by many inhumanities. Markoff produced data for MCI-Framingham that showed that once she trained the staff about trauma, the number of incident reports for inmate-on-inmate assault, inmate-on-staff assault, and grievances filed by inmates, fell by 1/3 after the training. Orientating the prison staff, including the correctional guards, to trauma, it seemed, had tangible effects on the relationships and interactions between staff and inmates as well as amongst inmates themselves. But was the teaching of trauma only a way to construct a calmer, more compliant, more docile, and more easily managed prison population, as Foucault would suggest?

Markoff believes that research by Catarina Spinaris on the high rates of suicide, burn-out and depression amongst correctional officers—what Spinaris has coined "corrections fatigue" (Spinaris, Denhof, and Kellaway 2012)—is the key to really getting trauma adequately addressed in penal environments. She explains:

I find that if I start talking about the impact of trauma on the officers, suddenly they are much more interested in what this is really about. And then you hear them say, oh yeah, we're all traumatized. So I think one of the ways into corrections, because they have a lot of power, the correctional officers, is through their own trauma, and once they understand their own trauma, they'll be less reactive because they'll get trauma treatment... but then they'll be able to recognize that what they're struggling with is what the women are struggling with.

Markoff admits that perhaps this is idealistic because correctional officers will always need to create psychological lines of difference between themselves and the people they guard. But

Markoff's approach is also dangerous, appealing to the somewhat morally ambiguous logic that that the perpetrators of trauma have the same psychological and physiological effects as those on the brunt receiving end of traumas. Didier Fassin and Richard Rechtman argue that thinking of trauma as the great equalizer of human experience is a dangerous, slippery slope: "The broad application of the concept of trauma makes it possible today to both recognize and go beyond the status of victim... by applying the same psychological classification to person who suffers violence, the person who commits it, and the person who witnesses it, the concept of trauma profoundly transforms the moral framework of what constitutes humanity" (2009:21).

Furthermore, taking such an approach to trauma means that the prison continues to be a central place for treating trauma. It does not re-site trauma treatment; it does nothing to divert women with complex trauma towards places in the community that are oriented to healing and well-being. The further imbrication of trauma therapeutic mechanisms does little to address the structural violence, the poverty and the violence against women that seems to overwhelm the biographical histories of incarcerated women who use drugs. It again locates pathology to the "seat of the soul" rather than recognize or articulate the violence of the state as well as the widespread neglect of these women by the state when they are not incarcerated.

Advocating for increased trauma treatment in prison is a dangerous position. While there is a general consensus that trauma treatment should be a community-based endeavor, the prison has increasingly encroached on this mission and adopted it as part of their rehabilitative efforts. Part of the prison's mission statement is to "Manage-Care-Program-Prepare." Is this how we envision care for the most vulnerable and the most sick in our society? How can the prison have appropriated trauma treatment and co-opted the language of care and healing for its own legitimization and perpetuation, when prisons and jails can do so much violence and harm to

people within its walls? Teaching trauma in the prison further legitimizes the very existence prisons and jails; it makes them a social fact, part of the fabric of social existence.

It is also important to know that there is very little stage two or three work being done with women with histories of incarceration and drug addiction upon their release into the community. There are certain agencies and individuals that are doing this work but there is a dearth of trauma-oriented community-based providers, particularly doing one-on-one psychotherapy. Markoff estimates that trauma treatment takes approximately "three to five years." She is confident that people can recover from trauma because women from the "ex-patient movement and the recovery movement" are out there, and we know that you can "completely recover." Yet who are those women? Are they poor, black, and formerly drug dependent or are they white, upper-middle class, with houses, financial resources and intellectual and social capital?

Alisha thinks that what she needs to recover is a one-on-one therapist in the community "where I can just vent. Just go and go hard. This is what happened to me... this is how I feel, you know what I'm saying." She lacks access to this, as well as to the socioeconomic resources to get back on her feet. She has been given a trauma-informed lens with which to inwardly peer at her own life, but she has nowhere to go with it. The prison touts its trauma-related "psycho-education" work that comprises carceral technologies of rehabilitation and attempts at moral uplift. The prisons and jails actively alter the individual subjectivities of incarcerated women but nothing dramatically changes in the socioeconomic conditions of the lives of these women, including their oppression and their disadvantaged political positioning within the state.

Women in prison learn through programming that they are damaged, possibly that it is not their "fault," but the treatment they get locates the problem within one's soul. Inmates are told

to re-narrativize the story; as Markoff suggests, "Helping women to craft a different story, which then increases their sense of choice and control, is really the bottom line." Yet the conditions of containment and confinement prevent the effective re-narrativization of the stories of these women's lives. What is the effect of empowering inmates psychologically while not addressing the structural violence in their lives, while not articulating and redressing how communities and social policies have abandoned many of these women, left them for dead?

The solution to trauma is thrown back to individuals who are disempowered, stigmatized and socially excluded by the very fact of being incarcerated; women are told that it is ultimately within their own locus of control to make informed decisions about how to best engage in the world in a rational and empowered manner. Teaching trauma in the prison legitimizes the very existence prisons and jails—in other words, it makes them a social fact. The vast prison apparatus, its employees and its agenda take on what Max Weber has called “the permanent character of the bureaucratic machine” (1946: 228) and instantiates authority in the prison system itself.¹¹²

What imbrication of medical and sociocultural logics supports the rise of “trauma rhetoric” in prison as a means to deal with traumatized, incarcerated women like Alisha, Shari and Serenity? And how and why does trauma become a stand-in for the experiences of poor women, their subjugation to poor men who experience the subjugation of rich men (and women)? I have attempted to show in this chapter that the prison’s emphases on trauma treatment in the form of psychoeducation and coping skills are a peculiar appropriation of

¹¹² Weber writes that “bureaucracy is *the* means of carrying ‘community action’ over into rationally ordered ‘societal action.’ Therefore, as an instrument for ‘societalizing’ relations of power, bureaucracy has been and is a power instrument of the first order—for the one who controls the bureaucratic apparatus” (1946: 228).

community-based trauma research and treatment efforts. *Rather than recognizing that trauma is often a collective, complex and historical experience of a group, the prisons selectively utilize the embodied, individualized and present-oriented approach to trauma that addresses superficial symptoms and behaviors.* This approach appeals to the prisons because they must “manage” these women (their suffering as well as their bad behavior like fighting) until their release, so containing the physiological and psychological imprints of trauma of women is advantageous.

While my longitudinal work showed that few women feel healed by prison programming upon their release into the community, the prison’s turn to trauma buffers its image as engaged in a paradigm of care that attends to the unique nature of gendered suffering. It is a selectively narrow technology of rehabilitation proffering a solution in psychopharmaceutical medication, breathing techniques and controlling one’s anger. And women in prison are eager to find words and ways to manage their ongoing symptoms and distress, as Shari’s case shows. They are genuinely desirous of healing and participate actively in new ways to conceptualize themselves, their suffering and their relationship to others. But the prison’s endeavor cannot reckon with what is actually at stake for women—to use Arthur Kleinman’s (2006) words—because to do so would be to articulate the prison’s own complicity in perpetuating traumatic experiences for the women behind their thick steel doors, barbed wire and prison bars.

Chapter 7: Embodied Deviance and the Carceral Production of Social Death: Lydia's Necrotizing Fasciitis and Her Death-In-Life

"Life exists only in bursts and in exchange with death." –Achille Mbembe (2003:15)

Shooting intravenous drugs means you are always in an unsteady dance with death, a partner who cannot be relied upon to lead or follow or to count the meter. Every time you load a needle, try to find a vein that isn't collapsed or shrunk into itself, draw the plunger back, check for blood, and release the drugs into your vein (or just jam it in anyways)—there is that risk that you might die in ten minutes, one hour, one day, one week. The drugs could be bad, the drugs could be too strong, the drugs could be cut with rat poison. There is a risk that your needle grazed the usually benign flora of your skin and that bacteria finds easy passage into the valves of your heart, from then on to your lungs and your brain. The needle can be dangerous, but what you do in order to get the drugs to put in the needle is also rife with danger.

This chapter follows one woman's relationship with danger and death as she moves in and out of hospitals and prisons and heroin use—her addiction trajectory, as Eugene Raikhel and William Garriott (2013) define the concept in a recent edited volume on the topic:

We understand the notion of trajectory to refer not simply to movement, but to directed movement, thus implying the forces and processes—whether social, psychological or biological—which shape this directedness. Seen in this light, addiction cannot be reduced simply to a biological condition, a social affliction or the symptom of some deeper malaise. Rather, it must be seen as a trajectory of experience that traverses the biological and the social, the medical and the legal, the cultural and the political. Understanding addiction requires attention to how it inspires movement across these multiple domains (2013: 8).

Lydia's heroin addiction is marked by this "directedness," although it is a direction comprised of the unevenly applied, indeterminate and murky forces of the social that bear down on all her decisions (e.g., why she asks someone to bring heroin to her in the hospital, why she chooses to shoot heroin only hours after release from jail). It is along this trajectory that she hovers close to

death. Death co-exists not-so-peacefully within Lydia; she has not “banished death from daily life” (Aries 1981) like the rest of us moderns. Her death, when it comes, will not be beautiful or elegant, her spirit will not be celebrated or memorialized; rather, it will be invisible and mostly anonymous, as Aries has suggested is the mark of our era.

This is the story of Lydia’s death-in-life. I tell it in detail in order to show how state institutions overlay death as a foreboding possibility in the lives of women who use drugs. These institutions (here primarily the prison and the hospital)—what Joao Biehl has called the “machinery of social death” (2001:136)—expose some to death and injury along the moral fault lines of our society. The so-called “mad, bad and sick” like Lydia are the ones who are bared to death’s grip. They are often the friendless, the surly, the unpleasant, the badly behaved, the ones that elicit disgust, the ones whose anxious presence seem unbearable.

Lydia has already died many deaths and will face many more deaths in the future. She has already endured the “civil death” wrought by being in prison, the soul-destroying experience of incarceration. Upon her release from the hospital after a bout with an infection known as necrotizing fasciitis, she resumes her life as a homeless heroin addict, living out an endless “social death.” On the streets of Chelsea, Massachusetts, she laments that she is a specter of her formerly “productive” self.

Maybe Lydia was already dead—dead to communities and passersby who drive close to where she was sleeping at night under a bridge. Maybe she was already dead to her family that disowned their lesbian daughter, the one who became a dopefiend and stole their furniture to sell it for drugs. Maybe she had become politically dead, erased from the voting rolls, no one’s constituent. Maybe her story is worth nothing to the voters that do not hear her against the promises of slick politicians on the ballot perennially promising they will be “tough on crime.”

Lydia has certainly been exposed to death, left for dead. She had also left others for dead, afraid of being found by the police in a house with a dead heroin addict and deathly afraid of being hauled off to jail. It is “worse than death” to be wracked with the rigors, sweats, shakes and the runs of dopesickness in a ten-by-ten cell with five other equally ‘sick’ women undergoing the unnecessary throes of institutional detoxification. Living close to death means living close to the vomit, the diarrhea, the fluids of bodies in revolt.

In Narcotics Anonymous, they have a phrase they like to use: “Jails, institutions and death.” It is a reference to the potential outcomes of unchecked drug addiction. In the Basic Text, the “Big Book” equivalent textbook for members of Narcotics Anonymous, it reads, “Our disease has turned itself into a constant threat of jails, institutions, and death, a threat against which we hardened ourselves all the more” (NA World Service Inc. 2008). Another NA pamphlet entitled, ‘Who, What, How, and Why’ defines “who is an addict” as “we are people in the grip of a continuing and progressive illness whose ends are always the same: jails, institutions, and death (NA World Service Inc. 1986).

Yet why are jails, institutions and death seen as the “natural” endpoints to unchecked drug addiction for this self-help, 12-step community-based drug treatment program that has meetings in thousands of towns across America every day of the week? In fact, this phrase reflects the unique historical trajectory of American drug policy that was being shaped decades before Narcotics Anonymous first met in 1953. Unlike other countries that have treated drug use and addiction more tolerantly, in the United States, incarceration was one of several primary social and political responses to drug use. Historian David Musto (1999) has noted that the history of American drug policy has swung between periods of liberalization and repression, between treating drug use as a sociomedical phenomenon or as one requiring a legal, punitive

solution. Consequently, prisons and hospitals have become two of the main spaces that have been made responsible for the social response to the problem of addiction.

For many individuals, though, jails, institutions and death are not the “natural” outcomes of drug addiction. In the 1960s, drug researcher Charles Winick first suggested that “spontaneous” recovery might be possible, arguing that some people just “matured out” of drug use around 35-40 years old (Winick 1962). Lee Robins (1973) found that 20% of the 898 men she interviewed returning from Vietnam reported being addicted to heroin, but only 10% reported narcotic use upon their return and only 1% reported becoming re-addicted (only 1% were found to have opiates in urinalyses). And many people who were previously dependent on drugs had succeeded in treatment; the documentary filmmaker and recovering alcoholic and drug addict Greg Williams set out in a 2013 film entitled *Anonymous People* to chronicle the stories of some of the 23 million people living in long-term recovery from alcohol and drugs.

Yet here I want to explore the lives of women like Lydia who cannot seem to avoid the inevitability of jails, institutions and death. Why is this so? How do they live in this circuit, as jails, institutions and death—in so many forms—permeate their lives in both drug use and their attempts at sober living? Hospitals and prisons and the prospects of dying are always close. These are the institutions that Foucault felt were the spaces of regulation and the exertion of state power—that is, what he called the “carceral continuum” (1979:303). In the United States, the criminal justice system and the medical system have become increasingly commingled domains, the front-lines of “examinatory justice” (Foucault 1979: 304), the spaces where biopolitics do work upon the poor and sick for the sake of managing their lives.

Necrotizing Fasciitis: Embodied Deviance

“And I don’t know what the fuck to do! All I wanted was my mother to let me come in [home]. And here’s the thing: they fed me pain medication at the hospital, they never treated my addiction, and what am I fucking going to do. I can’t go to a fucking detox, they won’t accept me like this, how do I fucking live? There’s no way in or out or anything, I don’t know what to do.” - Lydia, a week after release from the hospital for treatment of necrotizing fasciitis

“It is a fragile, threatened body, undermined by petty miseries—a body that in turn threatens the soul”-Michel Foucault (1986: 57)

It began as an abscess in her armpit with some kind of associated rash. These kinds of things are not atypical in the life of a heroin addict. Usually it can be ignored, until it can’t be ignored. Until it is too painful, too large, too red, too swollen or too hot. Until she feels a little bit too sick and too feverish, and the dope still can’t take the edge off. “You don’t look so good,” people say. “You should go to the hospital.” When prayers and shrugging it off yield little resolution, she finally comes into the hospital. In Lydia’s case: “I was in full-blown feeling bad. And as the pain got worse, the more drugs I did to get rid of the pain, the more delusional I became, the more crazed I became. By the time I got here, this whole [right] side, this was all swelled up.”

The doctor who examined her right armpit wrote in the chart, “Deroofed, draining (greyish fluid) abscess of the right axilla with swelling erythema warmth and induration noted inferolaterally extending down the right flank and to the right side of the back, extreme tenderness to palpation without evidence of subcutaneous emphysema, (+) urticarial rash bilateral lower extremities with excoriations noted b/l. BACK: Erythematous, warm, swollen, tender, indurated area, encompassing the right flank extending medially halfway to the midline. No evidence of fluctuance.”

In summary, “There is concern for necrotizing fasciitis and plans for the OR [operating room] are made emergently.” Rushing Lydia to the operating room for an infection, even a bad one, might seem a bit extreme, but necrotizing fasciitis is a soft tissue infection that could lead to

destruction of bodily tissues, septic shock, organ failure and death within several days. Infections like Lydia's enter the body through the skin via certain ports of entry—in this case, most likely a needle that Lydia's friend had used to try to drain an emerging abscess. Such an infection can occur in two populations of people: the first, immune-compromised--people with diabetes, peripheral vascular disease or recent surgery; and the second, in anyone with recent skin injury: trauma, childbirth, recent surgery, drug use.

After bacteria from the skin gets inside the body, it tracks along the fascia that keeps the muscles contained in certain arrangements, thriving in an environment with relatively low oxygen. It then leads to rapid multi-organ system failure and death; mortality rates, even with the proper therapy, are high—studies show mortality rates ranging from 14-59% (Kaul et al. 1997; Wong et al. 2003). The treatment for necrotizing fasciitis is an old and crude but efficient solution: cut the infection and the dead tissues out (debridement). Every 24 hours the wound is checked for more necrotic tissue. In Lydia's case, she went to the operating room seven times for debridement. Finally, she underwent a split-thickness skin graft from her right thigh to cover her side. She spent 31 days recovering from the initial debridement. The surgeons at the academic tertiary care hospital even removed part of her *latissimus dorsi*, a muscle in the upper side of the back, since that had gotten infected.

Image 7.1: Photo of Lydia in the hospital recovering from her surgeries, taken by author, used with Lydia's permission



Lydia was discharged after 40 days in the hospital. She told the hospital that she was returning to an address that was a room that she had been renting in Chelsea for \$200 a month, where she was allowed to sleep on the floor in the bedroom of her friend Juan and his girlfriend. The hospital set her up with Visiting Nurse Services who would take care of her wound and her skin graft. No one asked if her roommates were heroin addicts and if she would have difficulty abstaining from heroin upon her release from the hospital. Lydia was headed right back to the place where she had been actively using heroin only months before. In fact, at one point during her hospitalization, Lydia had even commissioned Juan to bring her up some heroin since her doctors were not giving her enough pain medication—"all I wanted was to be comfortable," she says in her defense.

I spoke to Lydia on the phone the day she was discharged from the hospital. She said she wasn't deemed "sick enough" to go to a rehab facility or another hospital. I asked her, what's the plan in terms of your—and I sort of cringed using the word—recovery? She told me flatly, "There's no plan." She said that she had always thought she would go to a rehab facility and that she would "take care of that [drug treatment] from rehab." She recounted a time that she had been inpatient at the same hospital as the one she was in now. One Sunday, they told her that her white blood cell count was down, and she could go "home." She asked to go to a rehab, and they found her a rehab hospital out in Tewksbury, an hour north of Boston. She refused, wanting to wait until Monday when the "real doctors were in the next day" but they made her leave that day back to the streets. "This hospital has done so much shit to me," she exclaimed bitterly.

Lydia's hospitalization makes clear the ambivalence that patients feel about these spaces of care. For her, it is a space of containment and confinement, imposing judgments, controlling her movements and her visitors. The hospital staff does not like it when she straps her

WoundVac (surgical internal system of drainage) to her IV pole and goes outside to smoke. It defies the hospital's order of things. Even though this hospital has saved her life, she feels the sting of perceived mistreatment. She fixates on the mean nurses not the kind and skilled phlebotomist that we once encountered. The world is generally antagonistic towards her and she has learned to respond in-kind.

According to the hospital's bureaucratic and calculating "logic of care" (Mol 2008), Lydia was, in fact, healing according to schedule and she had told them she had a "home," at least a place to stay. Rehab beds are few and far between, and staying in the hospital one more night is costly (on average, \$2,414 a day in Massachusetts according to 2011 data collected by Kaiser Family Foundation). Spending another \$2,414 on Lydia when she is "well" in order to buy time for the social worker to find Lydia a space in a homeless shelter or rehab facility is unfortunately out of the question. The "discharge plan" consists of "follow-up with PCP" and "attend surgical follow-up." Yet Lydia is far from healthy or well. Even though staying in the hospital one more night might allow the hospital to chart a more amenable discharge plan for Lydia that could possibly keep her from coming back, the logics of efficiency supersede all other possible logics of care.

I am worried about the seeming inevitability of her return to drug use since it is not addressed in her discharge plan. Lydia and I discuss maybe she should try suboxone maintenance therapy. I tell her she should get "home," rest, avoid temptation. I think that maybe she has realized how serious and debilitating her heroin use can be. I am naive to think that she is going to stay away from heroin.

She tells me, "I'm kind of relying on the suboxone to keep me sober." In my mind, I calculate the number of weeks it generally takes people to get onto a clinic or find a primary care

doctor willing to prescribe it. It is at least four, at minimum, if she is lucky. Of course, she could buy it on the street if she so-desired, although she would have to pay the street's mark-up rate. But why would she buy one suboxone on the street for \$10 when she could have the stronger high of heroin for the same price? She wants a quick psychopharmaceutical fix to feel better, just like we all do. She hangs up on me abruptly, aggravated, because she hasn't had any cigarettes and "Juan should have arrived twenty fucking minutes ago with her fucking cigarettes."

I think about Lydia and her bout with what is commonly known as 'flesh-eating disease.' It is by far the worst ailment she has encountered in her seven years of heroin use. The necrotizing fasciitis is literally an embodiment of her deviant moral behavior, one of the terrible outcomes of years of wicked bad habits like shooting heroin and cocaine together in what are called speedballs. It has eaten her old body, taken away her precarious "good health." It has left her more disabled than ever before, even more vulnerable to the vagaries of street life—of getting robbed, attacked, beaten up. She is left in disrepair in both body and mind; her new body disgusts herself and anyone who sees it. She has been surgically repaired and reassembled by tertiary-care level surgeons who put part of her thigh on her torso and back to cover up the gaping hole in her side. To them, she is a Frankensteinian success.¹¹³ They keep her at arm's length because, well, necrotizing fasciitis is often considered extremely contagious.¹¹⁴ We are all vulnerable to the bacteria she carries; her monstrous body makes us aware of how human we all are. Sociologist Margrit Shildrick argues that Levinas' notion of vulnerability is part of our

¹¹³ Sociologist Margrit Shildrick cites Aristotle, who "famously characterized the birth of girls as the most common form of deformity" (2002:12). She notes in her history of the monstrous woman that women's bodies have a long history of being seen as "out of control, uncontained, unpredictable, leaky" (31); their bodies demanded "policing and control" of medical men (42).

¹¹⁴ Orthopedic surgeon William Obrensky based at Vanderbilt University Medical Center tells a story about encountering a patient with necrotizing fasciitis and later coming down with it himself, not through the accidental surgical stick he received, but through the air spores and colonization in his throat of Group A Streptococcus, later to enter through an athlete's foot wound. For the full article, see <http://www.aaos.org/news/aaosnow/oct11/clinical4.asp>.

hesitant response to the suffering, possibly monstrous, other: “Although it is initially the other who is vulnerable, who is figured as homeless, poor, widowed, orphaned, and whose suffering humanity invokes response, that response itself—or rather the irresistibility of the call—pitches me also into vulnerability... It is my moral subjection to the other, my vulnerability in exposure to her vulnerability, that instantiates me as a subject” (2002: 92).

Lydia sees her new body as broken and raw. It does not function well. She grapples with what Gay Becker and Sharon Kaufman have called “the unknowable future” and her prospects of incomplete recovery to her former body and mind; like the people who experience strokes in Becker and Kaufman's study, she will experience the effects of “the inherent tension in American society between a cultural ethos that espouses productivity and individual responsibility and shapes policy to that end, and the vicissitudes of illness that interfere with those cultural goals” (1995:182). In other words, she will be made to feel responsible for her physical and mental “recovery” and her failure to do so.

We must understand her damaged body, recently wracked by infection and close to multi-organ system failure, not as the inevitable outcome of her choice to use intravenous heroin but rather as a situated and culturally produced entity, the end-product of social disgust and repudiation (a literal turning away) from Lydia, a possible source of contagion and danger. Like all of us are, Lydia is many things to many people: she is a daughter, a lesbian, a homeless person, a heroin addict, a fat woman who looks like a man, a drug dealer. There were many reasons to keep an arm's length from her. In fact, I was worried that if she asked me for a ride, I would hesitate for a moment too long and it would strain our relationship. She never asked. Much like Susan Bordo's analysis of the woman with anorexia, “She has learned all too well the dominant cultural standards of how to perceive [her body]” (1993:57).

Parking Lot: Precarious Life after Hospitalization

“But choices in terms of health and social policies, on employment and housing programs, on education and welfare, have concrete and measurable impacts on life expectancy, which is the average duration of life... Disparities in mortality rates are not only statistical data, they mean differences in values attached to lives.” -Dider Fassin (2009:53)

I find myself in a desolate parking lot in Chelsea, Massachusetts, clutching an iced coffee, my black coffee and two bags of food from Dunkin’ Donuts. Chelsea is a small town just north of Boston that is 62% Hispanic. It is very poor, with 23% of the population living below the poverty level and 44% living two times below the poverty level. It is home to many poor immigrants from Spanish-speaking countries, new immigrants from all over the world, and a substantial community of heroin addicts. And it is where Lydia runs the streets, her adopted home.

It is one week after she was discharged from the hospital. She is not at the parking lot that she specified. “Nothing with ham,” she insisted over the phone as I stood in Dunkin’ Donuts ten minutes earlier. “Maybe something with bacon.” “What do you want me to get you?” I demanded, beginning to get impatient. “My appetite has been all off since I was in the hospital, I’ve been feeling really picky about certain foods lately. No egg,” she says. I read off all the choices of food that Dunkin Donuts has and ultimately she settles on one after painfully long deliberation.

The parking lot she tells me to meet her at is behind a three-story apartment building. I sit holding her food on a little bench next to a dumpster, but I feel unsafe by the desertedness of the place, even though it is around one in the afternoon. I call her and she says, “I’m on the toilet.” I assume she is shooting up. I call my mom and wander a block over to the Chelsea Housing Authority elderly housing residence. I sit with a crinkled old white man who sneers at me for

perching myself on the benches of the Chelsea Housing Authority building. I wonder briefly if Lydia was setting me up to get jumped in the parking lot, but I dismiss that as distrustful and overly paranoid.

Finally, Lydia emerges, asks if I am in the parking lot and comes to find me at the more open-air benches one block away. Lydia takes me back to the parking lot but deeper this time and farther away from the road. We head to the back steps of this house where her friends are “passed out” inside.

A torrent of anxieties erupts. Her situation is not good, some might even call it dire. She speaks frenetically, in a staccato-inflected Boston-Italian accent; her voice is a fast, non-stop whine. Her housing situation with Juan, who has been her friend for ten years, is tenuous and he has kicked her out today after they had an argument. She is indignant because she noticed that he has been stealing her stuff—her Celtics cap, her body wash, new packs of underwear boxers she had gotten at CVS. Nothing is safe from him. “I thought I could trust him!” she cries out in frustration.

The conversation is heavily one-sided to her. She is clutching at her pants that have no belt. They must be two sizes too large. She is wearing a large men’s button-down shirt. Her mind jumps from the ACE bandages that Juan stole to not getting enough prescription pain medication to the amount of weight she has gained since her hospitalization. Then it is onto her constant fear of withdrawal and her inability to get enough pain relief. She tells me that she had asked her mother for some of her mother’s Percocets since her mother owed her \$200 and “refuses to give it back.” She accuses her mother of getting “high on [her] fucking Klonopins” and rarely taking the Percocets prescribed for her, even while her daughter is suffering in distress after ten operations. Her mother is refusing to offer a gift of pain relief, refuting their love.

While Lydia is narrating the recent events in her life, a young African-American man and an older white man drive up in a beat-up Cadillac right up to the stoop where we are sitting. They go inside but Lydia is convinced they are listening in on her. She whispers loudly to me, “I shouldn’t even be letting this guy hear this conversation,” but she doesn’t make any effort to steer us to another location. Her mind is a whirlwind. She feels completely alone, abandoned, bereft, with nowhere to go but the houses of other heroin addicts in the neighborhood. She is not yet sleeping on the streets.

Jackie, the one girl she ever really loved, is still more in love with the needle than she is with Lydia. Lydia called her up after her surgery even though they’ve been broken up for two years or more, pleading with her for help: “I said to her, listen, are you getting high real heavy? I was like, because I need somebody to help me.” Now Lydia is starting to cry, gasping in for breaths between tears the way an toddler sometimes does during a fit of rage and sadness. She begs her ex-girlfriend to help her: “Are you able to at least fucking help me put on my socks and shoes and maybe untwist my shirts and shit? She was so fucking high.” Lydia had tried, when she got out of jail two months ago, to get back together again with Jackie. She went and “partied with her, and offered to take care of her drug habit and make sure she would never want for fucking nothing if she would stop [prostituting].” Lydia left Jackie’s place in despair “because I wasn’t every fifteen minutes handing her dope, she fucking would do what she knew I didn’t want her to do, pick up the phone and call a trick to make money.”

No one is there to really take care of Lydia after her serious hospitalization, her brush with death. Julie Livingston has proposed in her work on Botswana’s lone cancer ward that people are forced to provide more care and perform a better job of it when biomedical treatments appear inadequate, fail in their commitments or are nonexistent. She speaks of the “open-ended,

bottomless nature of enterprise” of care.¹¹⁵ Angela Garcia (2010) has likewise shown in her work that acts of ethical obligation and care among heroin-using families in New Mexico. But in the retrenchment of social services, the opposite process can occur. Family and friends refuse pleas for care; they do not offer or cannot take care of the drug user in crisis. Urban drug use can often be a desolate, lonesome landscape. Lydia takes care of herself as best as she can.

Lydia made one human connection that helped her hang on: a visiting nurse, Cecilia, who came to Jose’s house once. She was gentle and taught Lydia how to take care of her wound, to paint the raw edges with sepia-brown iodine, and to wrap her bandage in a certain fashion. Lydia cried thinking about her goodness. The next nurse that came was negligent in her wrapping; she had a thick Caribbean accent and Lydia could not understand her at all. The bandage was too loose and the wound wept painfully.

“I’m not going to try to kill myself,” she says, sobbing, “But I fucking can’t wait for this life to end. I’ve been through so much and seen so much that I don’t need to see anymore.” Eventually, I learn later that the visiting nurse services were cut off because Lydia left Juan’s place that she had listed as her address. It turns out that visiting nurses stop coming to see you if you’re sleeping in parks or bouncing around from one friend’s house to another’s every night.

It was a precarious life to which Lydia clung that day in the parking lot. I could not understand why she wanted to live so much, why she grasped at life so tenaciously. Her life was a long lament: the misery caused by the needle, the pain caused by her wounded, slowly healing body, the trepidation of recovery into an unknown body with no place to go but the streets in which she was well-recognized as a drug-dealer.

¹¹⁵ Julie Livingston, Associate Professor History, Rutgers University. “Panel 1: What is Care-Giving?” Caregiving: A Medical Humanities Symposium. Harvard University. Cambridge, Massachusetts. December 6, 2010.

Lydia was trying to take care of her own wound as best as she could. While she was at the hospital for several months, she had taken things from her hospital room and given them to Juan to take home for her. “When I was in the hospital,” she explained, “and I do it even when I’m not hospitalized, when I go to the doctors, I go through the drawers and I take what I want. Every time he came up, I gave him a bag full of stuff: powder, those tiny shampoos, gauze, tape, scissors, ACE bandages. He swore to me that he never touched anything, we’d go through it all when I got home. I get home and all those thing he wanted are not in the bag, but he swears he didn’t touch anything.” She is furthermore upset because she had agreed to share the “stuff” with him; indignantly she remarks that she is “not a cheap piece of shit.” Yet they argue over who can have the extra towel. “I can’t have it? They were fucking in my room, I’m the one who fucking wanted this shit!”

I feel overwhelmed by the enormity and magnitude of her anxiety. No part of her mind seems to be at peace. I try to offer useful suggestions but she swats them away like she is going after a pesky gnat. My attempts at giving practical feedback seem less useful than just being a warm body, listening and offering sympathy.

What is perhaps one of the biggest sources of anxiety for Lydia is the fact that she might go back to jail, that she will be “picked up” by the police. “The last place I want to be is jail. I don’t want to go back. It’s so boring, and I can’t stand having fucking piss ants push me around and telling me what I fucking, when I got to go to bed, and the showers are horrible and the food sucks and if you don’t have money you’re fucked. And the girls are so immature, all they want to do is fight.”

She is fairly certain there is a warrant out for her arrest issued by a judge in Chelsea for receiving stolen property (two packs of cigarettes). This is because she was hospitalized during

the court date; for anyone who does not show up to his or her appointed court date, the judge automatically issues a “bench” warrant, allowing the police to arrest the individual in question at any time. I am not convinced that the jail would be a worse place for her than her nomadic existence shooting heroin and trying to take care of a full-body surgical wound by herself. But Lydia insists that her freedom is worth all the existential and physical anguish she is currently enduring. She doubts she would be able to keep her wound clean in jail nor does she trust the jail staff to take care of her in her debilitated condition. On top of that, she would not be able to endure the constant attacks on her dignity and sense of self that being incarcerated incurs.

What Lydia wants to do, in an effort to feel safer, is to walk over to a community-based organization where she heard that they have free, public computers. She wants to print out photographs of her surgical wounds and bring them to the courthouse: “I feel so much safer even with the pictures of the injury in my pocket.” For people like Lydia, very poor people who live on the street, the police are the danger. They are bearers of harm and suffering, not safety. So just having the printed copies of the photographs on her person will make her feel safer from the police. All the police in the area know her, and she is at great risk for being stopped by the police if she is homeless, wandering around, and buying and selling drugs: “The stigma sticks. The cops, it doesn’t even matter if I’ve been sober for months, and I had just relapsed that day, they all still treat me like it’s never stopped. They have no clue that I ever had a real life.”

When we pass through the doors of the community-based organization, we head to rows of gleaming new personal computers that are free to the public, intended primarily for people to look for jobs or housing. As we walk behind a row of computers, I see Lydia duck down quickly. She has found \$20. She turns to me, “I would turn this in and I really would... But over the past three days the amount of money that I lost, that I borrowed...” She trails off. “You feel bad about

that?” I reassure her that I don’t. Who am I to judge? She might use that money for food or water or coffee or ACE bandages or a couple of new pairs of underwear.

Lydia signs into Facebook, the popular social network site, to find pictures of her leg and torso that she had posted for her social network to see. I feel glad that we finally have a tangible goal, something that we can concretely work on to alleviate some of her current distress. She has difficulty locating the photographs. One of them, of her leg where they took the skin graft, she sends from her phone to the Facebook website. She pecks out the caption underneath: “It’s picking season!” She laughs to herself and mutters about her twisted sense of humor.

Then she turns to me and asks, “What’s Microsoft Word?” I realize the vast digital and educational disparities between us. I tell her what people use Microsoft Word for. I am surprised that Facebook has helped her bridge into a world of computers. I wonder if Facebook and cheap smart phones are ways that poor people, even homeless heroin addicts, are learning how to link up in new social configurations—to create virtual networks of drug users. I see that at one point Lydia had posted about heroin: in her words, “CHINA porcoilen white baby!”.

When we are navigating around on the website, she uses it to guide me through the important people in her life. She shows me her ex-wife, whose weave does not look as good as when she and Lydia were together when Lydia would pay for the expensive weave. All of a sudden, she sees a message from her stepsister that says, “My mother died.” Lydia starts to cry, because her stepsister had just yesterday asked her for money (“I’m hungry”) and Lydia had wanted to send her the \$75, but instead spent it on drugs. She tries to avoid thinking about her step-sister; she is too ashamed. I suggest that maybe it would ease her mind to send her a little message; I propose a trite one, like, “I love you and I’ll call you soon.” Lydia cries that such a response of trite, banal lies, is unacceptable: “I’m a fucking mess... I don’t know how to face her

right now, for the money and then this [her step-mother's death]. I just want to tell her that I hate myself right now.”

Finally, we manage to leave the computer area. Lydia walks me back to where I parked my car. On the way back, we meet two men walking separately who each greet Lydia effusively. Both of them are heroin addicts/part-time dealers; one of them tried to take over Debbie's customers when she went to prison, and one of them was fairly established on his own. The one who had tried to take over Debbie's customers had gotten swept up in the Chelsea police raid that happened three weeks earlier.

After we extricate ourselves from conversations with these men, I convince Lydia to visit a primary care doctor at the local community health clinic where I work occasionally. The clinic is in Chelsea and over the past three years, I had been involved in an effort to create a focus within the student-faculty collaborative clinic on the health of formerly incarcerated people returning to the area. One “unique” aspect of the clinic was the provision of co-located primary care and psychiatric services. I thought that since it was in her neighborhood, she might actually show up. And I felt paralyzed to help her; the clinic might be able to help, I hoped.

She seemed relieved that I would be there the night that I scheduled her two appointments (one with primary care and one with mental health), but she was hesitant. She wanted to test out the doctor first, see if they had rapport. I wrote down the appointment times that they had been able to make for her—three weeks from now (and that was an “expedited” visit). I would actually be seeing patients that night in my role as a 4th-year medical student, so I told her that I would be there to take care of her. Lydia was particularly interested in getting on suboxone for her heroin addiction. One of the primary care doctors at the clinic was licensed to

prescribe this medication, and I was hoping that would compel Lydia to actually show up for her visit.

We agree that if she wants me to come to court with her to try to clear her warrants, that she will call me. She says that girlfriend of hers, Nickie—also a heroin addict—might come with her tomorrow, but heroin addicts are too unreliable. Nickie probably wouldn't wake up or get organized enough to come with her in order not to be dopesick at the courthouse.

Three days after we meet in the parking lot, Lydia shows up at the hospital in order to get more pain medication. She shows up five days earlier than her actual appointment for surgical follow-up. The surgical resident writes: "Pt is a 42-year-old female with a history of IVDU who is POD#31 [Post Operative Day #31] from debridement of right axillary necrotizing fasciitis, POD #18 from placement of a split-thickness skin graft from her right lateral thigh to her right axilla, and now POD #1 following removal of wound vac [vacuum] from the graft site. The graft was noted to have 90% take. Of note, the patient was non-compliant during her hospitalization and would clamp her wound vac to travel outside to smoke. She was followed by acute pain and prescribed Dilaudid PO on discharge."

The resident goes on to address the pain control and her social situation: "She was instructed to follow up with her PCP regarding further management of pain. Upon discharge, she found that her roommate threw her clothes into the garbage and kicked her out of her apartment. She is now staying with her mother and friends and has not had time to see her PCP."

This story does not match up with what I know. I know that Lydia is not staying with her mother, because her mother refused to let her come back home after the hospital for fear that Lydia would steal from her. It is unclear if the surgical resident asked about any ongoing drug use or not. Perhaps Lydia would have lied about her resumed heroin use, or maybe she would

have admitted it and asked for better pain control or even detox. She certainly had not “had time” to see her PCP, nor had her future PCP had time to see her yet. Lydia was busy trying to hustle money in order to keep her pain under control and keep herself from being dopesick.

The surgical resident's plan was as follows: "Staples and sutures removed in clinic; Continue Bacitracin/Adaptic over graft until follow-up appointment on 8/21/13 given overall compliance and areas of open graft; Patient provided with one week of Dilaudid 2-4mg PO q6-8hrs PRN for pain with dressing changes and physical therapy (was previously taking 4mg every 4 hours). I spoke with her at length that she must see her PCP next week to discuss weaning her pain medication as this will be the last prescription we are able to provide because the wound is healing well. Reiterated importance of smoking cessation to help with wound healing and overall health."

The cut-and-dry surgical plan—the plan to make Lydia well—seems sterile and narrowly focused to me. I imagine that Lydia’s anxiety and high level of distress had probably not subsumed in the intervening days since I saw her and then the surgical resident saw her. She was also blamed for any poor healing that might occur because of her own behaviors, her ongoing smoking, her ongoing pain-seeking behavior that needed to be stamped out. As historian of medicine Charles Rosenberg has written, "One could always find reasons to blame the poverty-stricken and exploited" (1997:40).

The House of Correction and Civil Death

“We are not concerned with the poor. They are unthinkable, and only to be approached by the statistician or the poet.” - E.M. Forster, Howard's End

Lydia is living a death-in-life existence marked by uncertainty about where she will go and what her life will be like. Even in the absence of identifiable “disease”—the surgeon felt that

she was recovering nicely from her hospitalization—she is not well. Like Joao Biehl does so richly with *Catarina in Vita*, I hope to examine not only Lydia's current precarious state but what sociocultural and political forces have shaped her trajectory. What are "the bureaucratic procedures and moral actions that help to make these people socially invisible as they are abandoned to this most extreme misfortune" (Biehl 2001:133-135)?

In Lydia's case, the institutional logics and morasses create a bewildering, jagged mosaic of sensory experiences that culminate in an affect of despair. The institutions both tell her and mark her as bad; they leave her with stomach upset, headaches and a deeply somatized mistrust for hospitals and social service agencies. Lydia also lives with enduring and entrenched stigma that is written into her patient medical record—she smokes, she exhibits opioid-seeking behavior, she is an IV drug "abuser." As Lawrence Yang and epidemiological and medical anthropology colleagues have written about stigma, "In addition to compounding the experience of illness, stigma can intensify the sense that life is uncertain, dangerous, and hazardous" (Yang et al. 2007: 1528).

What made her feel that life was dangerous was mostly her fear of the police. What she wanted most of all was a life free from prison (the Suffolk House of Correction in Boston was her main captor) and from police that would bring her back there. She wanted a life on the outside, no matter how destitute or downtrodden. Lydia had been incarcerated many times before—at least twenty times. There were many reasons: for being homeless (trespassing), for buying drugs, for shoplifting, for selling drugs, for getting in fights. Like many other women told me, she would rather die than go back to prison.

Social historian Caleb Smith (2009) argues that the prison's power is intimately related to being a death-giving institution; in fact, it is a juridical-civil institution precisely intended to

enact “civil death.” His historical investigation into the early colonial Houses of Corrections and prisons as a uniquely American product sheds light on the complex notion of civil death. Smith summarizes the Gothic concept as:

A legal fiction indicating ‘the status of the person who is being deprived of all civil rights.’ In the United States, civil death statutes have dictated the felon may not vote or make contracts. He loses his property. In some states his wife becomes a widow, free to remarry without divorcing him. *Thus the incarcerated contact retains his “natural life” – his heart beats on, he labors and he consumes – but he has lost the higher, more abstract, civil life that made him fully human in the eyes of the law* (2009: 29; italics mine).

Smith explains how in the early American Houses of Correction—with major design input from the Philadelphia-based physician Benjamin Rush—the concept of civil death was intrinsic to the enterprise of punishment. Civil death was necessary for the act of incarceration to do its work at reforming the bodies and souls of the deviant; only in the prison would the individual undergo resurrection and rebirth into the human community upon his release. And only through the process of becoming a “legal nonperson comparable to a slave” (Smith 2009: 29) could individuals be properly stripped of prior sin and immorality, reformed by the prison, and learn how to govern their own behaviors upon release.

American prisons have a sordid history of dehumanizing poor people and people of color, in permutations of the convict-leasing system, chain gangs and slavery itself (Gottschalk 2006; Mancini 1996; Thompson 2010). The exact relationship between prisons, slavery and forms of racial and social domination is complicated; sociologist Orlando Patterson (1982) has argued that slavery is a form of social death, literally enacting a relationship of domination that psychologically and physiologically altered the enslaved and their communities. He has controversially argued that the widespread psychological and civil disavowal of entire peoples during slavery has had ongoing measurable (largely detrimental) effects on the relationships within contemporary black families and their communities.

Although Lydia is not black, she suffers from a specific kind of civil and social death that takes gender as one of its main determinants. She is routinely incarcerated in a House of Corrections, an institution originally conceived of in sixteenth-century England as combination poor-house and a work-house (Hirsh 1992). The “treatment” at the time—not necessarily for committing a criminal act, but rather for being poor and appearing idle—was hard labor. In the United States, the early Houses of Correction had similar moral, often Puritanical, overtones. In many of these early institutions founded by moral crusaders, women and men were housed together. Historian Nicole Rafter reports that “one penitentiary chaplain concluded that ‘to be a male convict in this prison would be quite tolerable; but to be a female convict for any protracted term, would be worse than death’”(Rafter 1990: 4). In these early Houses of Corrections, women were conceived of as a qualitatively different kind of inmate. Beaumont and Tocqueville noted that because they were so few in number, women were sorely neglected (Rafter 1990: xx).

Women from the Progressive movement—white middle class reformers—argued for a new institution: women’s reformatories. They were not interested in the “female felons held in custodial prisons but with a group not yet subject to state punishment—vagrants, unwed mothers, prostitutes, and other “fallen” women who seemed more promising material for their attempts to uplift and retrain” (1990: xxviii). Rafter argues this led to a penalization of women for relatively minor offenses, in which there were no equivalent sentences for men. Such a double standard stemmed from the notion that bad women were more dangerous than bad men. As criminologist Francis Lieber wrote in 1833, “The injury done to society by a criminal woman, is in most cases much greater than that suffered from a male criminal”; he believed that such a woman “acts more in contradiction to her whole moral organization, i.e., must be more depraved, must have sunk

already deeper than a man” (Rafter 1990: 12-13). This idea that women had farther to fall is a common sentiment that persists today in the ongoing “treatment” of women in prisons.

While much has changed in the “treatment” that women receive while incarcerated, the moral standards to which women are held and the criminalization of poor women continues. Lydia has lived through at least twenty incarcerations. “Fallen” from grace for many, no “treatment”—caring, curing or punishment—has led to her extrication from a life of drug use and petty crime. Indeed, Lydia is not healed by the time she spends in prison; rather, she has been contaminated and stigmatized by it. Mary Douglas, in her classic book, *Purity and Danger* (1966), utilized the prison as a case study of institutional contamination. As she wrote:

A man who has spent any time ‘inside’ is put permanently ‘outside’ the ordinary system. With no rite of aggregation which can definitively assign him to a new position he remains in the margins, with other people who are similar credited with unreliability, unteachability, and all the wrong social attitudes. The same goes for persons who have entered institutions for the treatment of mental disease (98).

And it is even more stigmatizing and contaminating for a woman to be locked up. Yet Lydia doesn’t mind when she’s among her fellow addicts. Being incarcerated has lost some of its sense of being beyond the pale in certain circles. The “War on Drugs” has slowly effaced the ritual pollution of incarceration in neighborhoods of concentrated disadvantage like Charlestown and Chelsea. It is now a place for the suppression of the rise of what Diana Gordon (1994) has called “the dangerous classes,” where one’s bad habits coincide with social policies that punish the poor (Wacquant 2009).

Court: The Threat of Civil Death Persists

Sociologist Beth Richie (2012) argues that women like Lydia are particularly unprotected from the state; in fact, in many ways they are hurt by the state services and institutions that claim to be protecting them. While mainly interested in the violence against and endured by poor black

women in communities of concentrated disadvantage, Richie uses the term “prison nation” to outline why the reliance on the formal criminal justice system and associated bureaucracies of control and surveillance has made women more vulnerable to ongoing violence and hardship. As she writes from a black feminist perspective, women who appear deviant in sexuality or ethnicity often become embroiled in carceral social services and institutions because of the ‘prison nation’ apparatus, which includes:

(1) practices that increasingly punish or disadvantage norm violation (adolescent pregnancy); (2) institutional regulations designed to intimidate people without power into conforming with dominant cultural expectations (welfare reform); (3) legislation that deliberately narrows opportunities for cultural expansion (English-only laws); (4) and ideological schemes that build consensus around conservative values (the primacy of heterosexual nuclear families) (2012:3).

Lydia faces an endless threat of becoming incarcerated in the era of Richie’s “prison nation” with her norm violation (lesbianism) and her lack of conformity to “dominant cultural expectations” (homelessness and heroin use). Like other women on probation, parole, home supervision, welfare, and other forms of state supervision of the poor, the constant policing of her behaviors means she is more likely to get arrested for petty actions.

I had hoped to help her clear her name in the Chelsea court system, a minor victory if it could even be accomplished. She had been worked up all weekend. Tanya Lurhmann writes that “subjectivity implies the emotional experience of a political subject, the subject caught up in a world of violence, state authority and pain, the subject’s distress under the authority of another” (2006:346). Lydia, even in her “free” life on the outside, was wrecked by the constant threat of the prison’s ever-widening shadow, her distress under the authority of the state’s police power. Her emotional state spoke to her anguish at subjectification and subjection.

So I was not entirely surprised when I got a phone call from Lydia at 8am the next Monday. “Did you just call me?” she asked. No, I said, half-asleep. “Are we going to court

today?” she asked me. Then she started in on a litany of issues: “I don’t even know where I am. I don’t have any clothes. I’m wearing the same clothes.”

I head over to Chelsea. We agree to meet at the Dunkin’ in front of the courthouse at 10am, to give her enough time to get dressed. I am crossing the bridge into Chelsea from Boston when I get a phone call from Lydia: “I fell back asleep, after we talked.” An hour later, after I sit in Dunkin’ eating a buttercrunch donut, Lydia arrives. We store her phone and some papers in the trunk of my car. She told me that she was late because she was taking a back alley route in order to avoid a cop car that she saw.

After going through the metal detectors, throwing out our coffees, and putting my phone back in the car (“no camera phones”), we head into the courthouse. It is mostly empty, unlike the bustling Boston Municipal Court. Most people are standing in line at the court officers. Apparently the first person that needs to see Lydia is her probation officer. The probation officer is a dour-looking, middle-aged Hispanic lady with short-cropped hair. A flash of recognition lights up in her eyes as she sees Lydia. The woman calls Lydia over: “I’m going to detain you [in jail]. I asked for detention for you. Did you go to that program?” Lydia protests, mumbles about being in the hospital. The probation officer is angry and seems intent on sending Lydia to jail. She appears to have made up her mind as soon as she laid eyes on Lydia. This is not “bureaucratic indifference” (Herzfeld 1992). This is bureaucratic ill-will.

First, though, the paperwork. Lydia gives all this information, stating her address at her parents’ house in Medford. I notice the probation officer misspells much of what Lydia says to her even when Lydia spells it out. The probation officer finally turns and acknowledges my presence: “What are these surgeries for? Who are you?” And to Lydia: “Is she authorized to speak on your behalf?” Yes, Lydia responds. I tell the probation officer I’m a Harvard medical

student and that Lydia recently had necrotizing fasciitis, that she just had six or seven surgeries. We place down the pictures of Lydia's surgery. The probation officer doesn't really look at the photographs, even though Lydia was so insistent on the photographs as the ultimate proof of her suffering. "Fine," the probation officer says. "At least you're getting medical help," she waves to me. "I'm going to go in there and say you need a date for a final surrender hearing."

Lydia and I head to the bathroom before heading into the courtroom to wait to see the judge. Lydia is crying, dabbing at her eyes. I try to console her, "Hey, we got what we wanted right? You're not going to jail." "I can't go there [to jail], not with this!" she says, motioning to her bandaged right side. "That bitch! She was gonna send me to jail, you heard her."

Lydia and I head off into Courtroom 1. It is overly air-conditioned inside, perhaps in order to keep everyone awake. Lydia keeps nodding off next to me, her head falling down and jerking back up. We spend so much time in the courtroom that I have to go feed the meter. Chelsea is such a relatively impoverished municipality that you can put nickles and dimes into the meters.

The judge finally calls Lydia's case and gives her a new court date and a pro-bono lawyer. Lydia asks for a "warrant recall" and the lawyer moves her hand like, meet me outside the courtroom, except she doesn't show up. We don't know where to stand in order to get a warrant recall, but as Lydia explains to me, if you don't have the piece of paper in your hand, sometimes the computer system doesn't register that the warrant has been recalled. This has happened to her before apparently. She insists on having the paper in order to feel protected from the police.

A thin young woman with white blonde hair spots us as we wait in line for a warrant recall. "I've been looking for you," she says to Lydia. "I came to court for Chris but I came too

late. It already happened. He has 9 months in Walpole [MCI-Cedar Junction-Walpole, a maximum security men's prison]." She waits to walk out with us, probably because Lydia can hook her up with drugs afterwards. Lydia asks her if she heard about the two girls who were hacked up with machetes last night by the Mexicans in the square in Chelsea? "Little Tara?" the girl asks. "Oh Tara. Yeah I know her. She cussed out my mother one time." The women have a discussion about what those two girls were doing robbing men. "You know how the girls are," Lydia says, "they go out, they rob their tricks." The young blonde woman chimes in, "And usually they get away with it too." Lydia, who is Italian, goes on to talk about how many "wetbacks she used to rob." Her friend acts like the girls got what they deserved: "They shouldn't have been what they were doing."

It strikes me that these two women who are heroin addicts can talk so dispassionately and a racist fashion about the incident of acquaintances—other women, probably addicted to substances, living dangerous street lives—who were supposedly murdered with machetes last night. I am beginning to see the finely-grained moral hierarchies of the street. People perceive themselves to be different, or they must perceive themselves as different in order to psychologically maintain or justify their actions, to keep on in a dangerous environment and lifestyle.

It is an exhausting morning. I am not sure of what would have happened to Lydia if I had not been there with my doctorly cardigan and conservative shoes to vouch for her, to wield my social capital to swing the powerful bureaucratic ill-will of the probation officer more in her favor. I am certain that if I had not been there that she would have been sent back to jail for the bench warrant issued when she did not show up to her court date for receiving stolen property.

The cycle of institutionalization would have continued. Lydia would have endured a painful detox from opiates in jail, and the cycle would have gone on, uninterrupted. Business as usual.

The Prison and Risk of Death

What is important in this case is how Lydia's emotional state is dictated by a harshly gendered form of punishment, a civil death for a woman who dares to pass as a man, who sells drugs, who perceives of herself as an underdog and someone fighting for her fellow underdogs. Her embeddedness in the carceral system makes extrication from its maws nearly impossible.

She also faces significant risks to her chances at achieving health and happiness upon walking out of the two interlocking steel-plated doors of the jail. She had done this three months earlier, after spending three months in the Suffolk House of Corrections for something she adamantly insisted she did not do. When she bailed herself out after her next court date, she said goodbye to all her friends, wishing them well. She changed out of her jail clothes and back into her checkered boxers, her jeans, her collared shirt—the clothes she was wearing when she was arrested. Juan is waiting with some heroin. She cannot wait to get high, she feels it in her body and breath and fumbling fingers as she gets distance from the jail. Time to party, she tells Juan.

Ingrid Binswanger, a physician at the University of Denver, conducted seminal research that indicates that leaving prison is risky business. Rates of overdose within the first two weeks of release from prison are staggeringly high, both anecdotally and in Binswanger's study (they found that someone leaving prison has a 129 times higher relative risk of overdosing than someone from the general population). She and her colleagues' 2007 study examining rates of mortality among people living prison in Washington State showed that the adjusted relative risk of death among former inmates in the first two weeks out of prison was 12.7% higher than the

that of the general population. The mortality within the first week of release was even higher.¹¹⁶ Interestingly, “Mortality rates did not return to the baseline of the general population of the same age, sex, and race even several weeks after release” (Binswanger et al. 2007:161). This research was supported by work conducted by Anne Spaulding and her colleagues (2011) that showed that long-term mortality was significantly increased among men who had been incarcerated fifteen years earlier.

Sociologist Evelyn Patterson concurs that prison is an institution that is bad for your health. She notes that for women in particular, prison was particularly “detrimental to females in comparison to their male counterparts in the period covered by this study” (2010:587). She calculated the “years of life lost” by incarceration status: “During the first period, 1985-1987, male prisoners lost 13% more years of life than male nonprisoners, and female prisoners lost 76% more years of life than female non-prisoners” (Patterson 2010: 593), although she notes that these disparities diminished slightly over time.

There are many reasons that people are at risk for overdose upon release from prison. One is loss of physiological tolerance—that is, relative abstinence from drug use during prison leads to a normalization of neurobiology. Using one or two grams of heroin can overwhelm the brain’s opiate receptors, leading to the suppression of the brain’s respiratory center. Some people take it slow, knowing that they are increased risk upon release from prison, and might do a “tester” shot, or shoot a small amount, and then do more soon thereafter. But the goal is to get as close as possible to overdose without actually overdosing.

The Boston Public Health Commission sponsored an overdose prevention effort led by a Boston neighborhood coalition in the Suffolk House of Corrections. The intervention was to train

¹¹⁶ Of importance to the theme of overall poor health outcomes among people who have been incarcerated is the fact that the second leading cause of death was cardiovascular disease. Suicide, homicide, cancer and motor vehicle accidents were also important causes of mortality after release from prison, see Binswanger et al. 2007.

and certify volunteer male inmates in the drug treatment division of the jail to learn the signs of an overdose and learn how to reverse an overdose with naloxone (Narcan). They could then pick up several doses of naloxone upon their release across the street on Albany Street at the Boston Public Health Commission offices. If used within a certain time window, the naloxone can prevent a fatal overdose. The curriculum instructed the teacher to explain why inmates were at such high risk of overdose. In addition to physiological reasons, they addressed the psyche: “More experienced users are at an increased risk because of higher levels of use, and previous overdose increases risk of future overdose because people have tended to become less concerned about it, once they have survived, and those who have overdosed before may have drug use patterns that put them at risk for an overdose in the future” (Roxbury/Jamaica Plain Substance Use Coalition 2013:11).

Overdosing, therefore, can be seen as the physiological and neurobiological (embodied) outcomes of psychological processes working in conjunction with cultural and social forces that converge on individuals. It is important to foreground the decision to use drugs upon release from prison. It is helpful to think about these decisions to use or not use as the sociologist Alford Young (1999) has theorized agency in relation to structure, as the capacity for individual action grounded in a psychological context in which options for action are perceived as limited and narrowly defined given certain cultural and historical frames of being-in-the-world.

Why some women decide to pick up heroin immediately is often a decision that is made weeks or days before the actual use of the drug. Incarcerated women often feel torn; they want to stop using, but they also intensely mourn their loss of freedom. They feel that prison is a massive interruption (of varying lengths) in their lives. They often feel compelled to make up for lost time, to blaze more brightly and strongly than slowly. As public health practitioners or clinicians,

we counsel them to do tester shots, do a little bit. This is precisely what they do not want to do: take it easy, take it slow, do more later. Their greatly elevated risks of overdose just upon release then are directly related to the fact of having been incarcerated. Incarcerated women who use drugs upon their release tend to crave more intensity, wanting to feel and experience a rush of drug effects as a result of being involuntarily confined (and usually abstinent) in prison. The structural violence of incarceration primes them to willfully abuse their agency in the direction of self-harm.

In Lydia's case, she wanted to be able to exert autonomy over her body and what she would and would not do with her time, even if she knew they were conventionally "bad" or unhealthy ones. She wanted to experience the liberties of being a "free" woman out in the world. She left prison shortly after she had a court date, getting time served for one case, and getting \$200 bail for the second case. She returned to jail briefly and bailed herself out. She started using immediately; as she explains, "I didn't have a habit, but throughout my partying I got robbed." She was back in her stomping grounds—Revere and Chelsea: "I got robbed in Revere when I was getting high. I got robbed for \$3000 that week [first week out of jail]. I got robbed almost everywhere, almost all the places I went partying, but that's because I was being overly generous. People saw that I had money, drugs and I was being overly generous. Nobody needed to rob me. But I got overly high and they would take advantage of that fact." Lydia was doing her favorite: speedballs (injections of heroin and cocaine). She had nowhere to go and would stay with different people—two white females, a white gay male, a black gentleman—in exchange for drugs. As she would put it to them, "Let me stay the night, then I'll get you high all night long."

Yet she felt vulnerable to the predations of not-so-friendly acquaintances who took her drugs and money. Why did she keep doing it? Stupidity! I'm so stupid, she says. Why can't I stop? When we talk more, it becomes clear that she hoped to re-unite with her girlfriend. Old faces, not exactly friendly, were more welcoming than her family who shunned her. It was better than being alone. And like other women in my study, she felt that getting arrested and having to go to prison was an irritating and unwarranted interruption in her life.

Serenity also felt that prison had interrupted her life. It was, therefore, her "mission" to finish where she had left off when she had gotten arrested. As she told me when we reconnected when she was re-hospitalized with a cellulitis infection of the neck and chest, "Every time I go to jail I feel like they interrupted what I was doing and I'm not ready to stop yet, so I still have that mission to complete. And so that's why I go out a lot [to the streets to use]." She was released into Boston's mild and balmy summertime, a season unfortunately conducive to drug use, when being homeless is not so unpleasant.

Longitudinal social science studies similarly suggest that being incarcerated is a factor in long-term poor health outcomes. Sociologists Susan Sered and Maureen Norton Hawk conducted an archival study of 839 women released from MCI-Framingham in 1995 (Sered and Norton-Hawk 2011). Of those women, they found that at least 97 of the women had died within fifteen years of release from prison; the median age was 44 years old, the primary cause of death included alcohol, HIV/AIDS, drug overdoses and pneumonia. 44 years, almost half of the life expectancy of a woman in the United States—81 years old. The life spans of the women they followed were more equivalent to the life expectancy of a woman in war-racked Sierra Leone or the Democratic Republic of Congo than in one of the country's intellectual and urban centers, home to some of the world's "best" hospitals.

A Townie and a Guinea

Lydia has always lived around violence and death. Part of her seems to not mind if she dies young, having “seen enough of life,” but part of her longs to get a job, conform to middle-class mores and social expectations. She always wanted to have a family and kids, a wife, her own apartment. All these things have eluded her. Perhaps it was because she grew up in Charlestown, a fighter, a dreamer, a guinea (derogatory ethnic slang for being Italian).

I first met Lydia when she was in the Boston jail serving a three-month sentence. She was in a bad mood because she had just had to say goodbye to her girlfriend who had been released earlier in the day. She was also fixated on not having showered in the past several days and was worried about smelling bad. She had no time to shower, because her girlfriend was leaving, and they wanted to spend a quiet hour together in the yard before she left. She also felt self-conscious because she was not wearing a bra, since one of the other girls was supposed to wash it but hadn’t finished it yet.

At first glance, Lydia, who goes by the name Leo when she is in prison, appears to be a man. She is short and usually wears her now graying hair shaved close to her scalp. She is also fat, a fact that she bemoans, as it tends to indicate to her a soft and aging body that is slowing down. Meeting Lydia for the first time, I was struck by her thick black eyebrows and facial hair above her top lip, her gender non-conforming body. She exudes an aura of toughness, pugnacity even; her hands curl up almost instinctually into fists sometimes when she talks, and she looks like she’d be at home on a construction site or a boxing ring.

It surprised me that Lydia always had girlfriends, until I realized that what she probably has to offer is a lot: that is, her street-smarts and the desire and ability to provide a sense of safety to many women. She wanted to and was generally able to fulfill many of the roles of a

desirable street partner, usually performed by the male—procuring drugs, taking on the legal and physical risks associated with getting drugs, etc. When she and I were walking the streets of Chelsea, Massachusetts, where Lydia’s roams using and selling drugs, she told me to “walk on the inside of the sidewalk, and she would walk on the outside closer to the cars, so no one would think I was working [prostituting].”

She reminisces about life in Charlestown in the 1960s and the 1970s. It was a different time back then. The Mafia ran Boston. The city was rife with racial anger and violence over busing. Charlestown in particular was a neighborhood iconic of white violence, the mob, working-class first- and second-generation Irish and Italian families. Charlestown is a sort of city within the city located just north of the Charles River and adjacent to the Boston Harbor; it is home to the famous Breed and Bunker Hills of the Revolutionary War-era. Perhaps it is most notoriously known for being the neighborhood of poor Irish families. Also known colloquially as just “the Town,” Charlestown was made famous by a 2010 Ben Affleck movie of the same name drawing attention to the notorious local occupation of bank robbing.

Lydia describes growing up in an unsavory, yet notably historical moment era in Charlestown. Her family was one of five Italian families in an all-Irish block, and her father was a bank robber who went to jail when she was three years old (another one of the women in my study grew up in Charlestown, and her father was also a bank robber, and she was incarcerated for robbing a bank to get money for drugs). She remembers growing up when the “Code of Silence” was rigidly enforced. She was forced to fight often, for being an out-of-place Italian child and she thinks it was also obvious that she was a lesbian, even though she had long hair.

Lydia’s fondly remembers having done an errand for Whitey Bulger, the notorious Boston mobster who ran an Irish gang all over Boston with his Winter Hill gang based in

Somerville.¹¹⁷ She was ten years old when she had to do an errand for Whitey: “ And I did a little job for him. I was supposed to get rid of a car for him, here there is this kid cruising, yeah, who cares. Yeah I wasn’t such a good kid. I was a troublemaker, but I had a good heart. I was always for the underdog, probably because I felt that way.”

There was a lot of silence around personal and interpersonal dysfunction growing up. No one talked about anything disturbing, wrong or bad. Lydia was pretty certain her father abused her mother, but they grew up in an era where women were routinely beaten by their husbands and said nothing about it. “You’re just supposed to take it, nothing was supposed to be said outside the house.”

Lydia experimented with drugs (mescaline, weed, acid, cocaine) but she didn’t really start using heroin until later in life. She held down many jobs, including a long stint for Teamsters as a pharmacy assistant. At 35, her life started to go downhill rapidly. She met an African-American/Puerto-Rican woman named Rita who was 18 years old but lied and said she was 21. They got married at Rita’s insistence. Meanwhile, Lydia’s brother had a stroke. He was young and Lydia was struggling to take care of him. Rita was physically abusive; Lydia left her and was homeless, living under bridges. When she was incarcerated for being homeless (for trespassing), she was locked up and she met Jackie, whom she considers the love of her life. Jackie was the one who introduced her to heroin. They actually met in jail as cellies (cellmates).

¹¹⁷ Whitey Bulger is a contentious figure in Boston’s criminal history. His recent capture and years of terrorizing Boston are recorded by Boston Globe columnist Kevin Cullen and Shelley Murphy in *Whitey Bulger: America's Most Wanted Gangster and the Manhunt That Brought Him to Justice* (2013). *Memorist* Michael Patrick MacDonald remembers that growing up in Southie, Whitey ruled all: “Whitey stepped up as our protector. They said he protected us from being overrun with the drugs and gangs we’d heard about in the black neighborhoods, as well as stopping the outsiders who wanted to turn the projects into expensive condominiums. I knew there were drugs and even gangs in my neighborhood, but like everyone else I kept my mouth shut about that one. Whitey and his boys didn’t like “rats.” And it was all worth it to look the other way as long as Whitey kept the neighborhood as is, and we kept our ten-room apartment for eighty dollars a month... Whitey Bulger was the only one left to turn to. He was our king, and everyone made like they were connected to him in some way” (1999:110-111).

Lydia recounts how they got together: “Just when I got comfortable with Jackie being my cellie, she moved out. I was so fucking offended. I guess her and this other girl had been trying to be cellmates for a while and it finally came through. At that point we weren’t even talking to each other at that level... I was on [floor] 9 and she was on 10. When she was on 10 I heard somebody say to me something about my girlfriend, and I said who’s my girlfriend, and they said Jackie. So we got to know each other a lot through letters before they moved me upstairs [to 10].”

Jackie and Lydia got released from jail a week apart and they stayed together for five years. After they got out of prison, Jackie went straight back to shooting heroin and would “pass out immediately.” So Lydia tried it, first by sniffing for three days or so, but as she was jealous that Jackie was getting “instantaneously wrecked.” Lydia first learned how to shoot up in her foot, because she learned from Jackie, who had used up all her other veins: “I would shoot up in my foot because that’s where she was shooting up. I remember back then if I didn’t shoot up in my arm, then that meant I wasn’t a fucking addict or a junkie.”

It was difficult for Lydia to use too much heroin herself because she was always “babysitting” Jackie, whom she was afraid was going to always overdose and die “because she popped a lot of benzos and did a lot of dope.” Lydia felt that taking care of Jackie was her life’s mission, until she realized that she couldn’t “save” Jackie and was simultaneously going down with her into a life ruled by her heroin addiction. Jackie’s use was frantic and manic at times; she would shoot up ten times a day or more, driven by the haunting memory of own mother’s death by heroin overdose. Jackie had been using with her mother at the time her mother overdosed and died, and she was too “wrecked” to realize her mother had not just “nodded out” but died. Meanwhile, Lydia babysat her. She felt responsible to and for Jackie’s relative safety while Jackie flung herself nonchalantly into the abyss of poly-drug use.

Post-Incarceration Primary Care Clinic: Medicine as Risk Reduction?

Even though she was no longer dating Jackie, Lydia still couldn't shake her physical dependence on heroin. She had been to one now-defunct community-based drug treatment program for three months, but she relapsed at drug-filled halfway houses upon completion of that program. There were too many young beautiful women who could get drugs and attached themselves to her.

I hope that she might be able to find some respite from her harried life in the post-incarceration clinic was in her neighborhood. I call her to remind her of her appointment the day that she is supposed to come in. She says she is planning on coming in, reporting that her habit has worsened to approximately two gram of heroin a day (one gram more a day than usual because of the pain from her wound) because she had been cut off the prescription pain medication refills. She thinks that her side has gotten re-infected, although she has been cleaning it as best as she can.

I encourage her to come in to the clinic in several hours and assure her that we can help her. I am secretly worried, though, that we can't help her. What can we do? Suggest she go into detox or go back to the hospital where she was discharged so cavalierly back to the streets to be homeless and begin heroin use again? The same hospital where she felt like she was treated like shit, entirely disrespected?

I notify the team at the clinic that she is coming because she is sending me text messages at every step of the way as she tries to get to the clinic. She is ten minutes late, then twenty minutes late. The teams of students able to see patients are in short supply, and I am holding out with my first-year medical student to wait for Lydia. She keeps sending me text messages: she is on the bus. She is coming from Revere where she has been staying at Jackie's house using. Now

she's at the place where she is keeping all her belongings. She is waiting for another bus now. Finally, after my gentle prodding and much encouragement, she shows up, about thirty-five minutes late.

In the meantime, I have been trying to teach the medical student about necrotizing fasciitis. I am also interested in teaching him the 'social medicine' aspects of a patient like Lydia. How can we get her to clinic? What do we expect to do for her here and what does she expect us to do for her? How can we achieve an encounter where everyone feels like successful "work" has happened? How can we address the upstream causes of her poor health—like her homelessness and ongoing heroin addiction—from the outpatient community clinic visit where we have one hour to see her? My first year medical student is eager but confused. This is not an ordinary initial patient visit.

We decide with the attending and with the 4th-year psychiatric resident that we will have a mini-intervention to try to persuade Lydia to go by ambulance, voluntarily, to the emergency room, where she can be screened for different levels and kinds of services: inpatient psych services, inpatient medical services, detox facilities, or a combination thereof. I wonder if she will be amenable to going in an ambulance tonight; we decide that if she does not want to go, that we will not try to involuntarily commit her, nor does the psychiatric resident think we will not have the grounds to do so.

When Lydia finally shows up, I sigh with relief. 'You didn't have to come in tonight,' I say, congratulating her for the work that was necessary for her to get here. A lot has happened in the few weeks since I last saw her. She was staying at a friend's house— a fellow heroin addict—and a couple of them left to get food. When they came back, they found her dead of an overdose. Lydia is a wreck over that and everything else.

She holds a baseball cap in her hands and twists it around, her eyes sparkling with tears about to spill out onto her cheeks. I try to calm her down, reassure her. I had told the medical student that the basic things that we usually try to do on the initial visit might not get done. For example, we might not take a full past medical history, or check her labs for diabetes and cholesterol, or give her immunizations. We spend about five or ten minutes listening to what has been going on, then I go get the psychiatrist for our intervention. Three people from the mental health team—the head of the department, a social worker; the psychiatric resident; and a nurse-practitioner student—crowd into the tiny exam room with me and my medical student. It must be intimidating to Lydia.

The psychiatric resident takes the lead. He asks about previous suicidal ideation (four attempts), homicidal ideation (none she reports). He asks carefully about which drugs she has used and how much and when last. After recording her history of suicidal ideation and several attempts, he pauses. He asks about heroin use, cocaine use, benzodiazepine use and alcohol use. Finally, he suggests our idea: that she go by ambulance for evaluation to the main emergency room and most likely admission to a combination pain-wound care-psychiatric facility and detox. She agrees, but hesitates, “I want to go in. But I didn’t know tonight. I left my wallet and stuff at this lady’s house that I’m staying at. I want to have my wallet, have my stuff.” So we agree that she will come in the next morning at 9am after picking up her things. She will show up to see the head of the mental health department tomorrow. She wants to go, she insists.

I take her to another room and the primary care attending comes in. We help Lydia change her wound. It is a sight to behold. My first impression of her healing skin graft is the raw skin of an uncooked turkey wing. I am very careful as we wrap underneath her breasts, clean the area. Nothing looks like pus. It actually does not look infected.



Image 7.2: Photo of Lydia's healing wound, taken by author, used with Lydia's permission

I make sure to ask her several times if she is comfortable with the way we wrapped her up. I knew from the past that she had been doing it herself a particular way, and that the nurses had done it in some ways that made her feel dissatisfied or upset later on. She said we had done a good job. The attending who is supervising me wants to get some blood drawn for diabetes, cholesterol, HIV, Hepatitis C viral loads, and to check immunization status. Lydia pleads with her, no, can't we do that another time? My veins are shot. I argue for their lesser immediacy and talk to my medical student about coming to a middle ground, the necessity of establishing rapport and trust during the first visit. How can we work on the issues of social and structural violence in her life if she does not show up ever again because she thought we didn't respect her wishes, if she thought we didn't pay attention to her opinion?

The next morning, Lydia does not show up the clinic. She did not show the whole day. A month later I got a text message, “Kim its lydia I was tryn to wait for check day [SSDI check] but its so bad I cant take it.” She did not return my calls or my responses. One month later, “Kim I really want to try to get into a place u guys were telling me about my side is gettn worse what do I do im ready to go.” I encourage her to come back into the community clinic and see the doctors there. She promises she will come, “yes I need this & my side is def gettn worse.” Again, the next day, she sends me text messages, a play by play of her whereabouts and actions. I respond to all of them, encouraging her as best as I can.

Several hours go by, “Ooh im just now able to get into the house I had to leave the last time I textd u so she could make \$\$ [prostituting] so we wouldnt be sick my body was just so achy but im just” “now able to shower&get ready2go the only thing thats ok about it is im only a bus ride & a few block walk so once im on the bus it only takes me 15-20 to get there.” An hour later, “within the hour, I’m almost ready to leave.” Later, “I’m on the bus now im scared! Will they find me some place cuz now im out on the street if not.” I am scared to reassure her, because I don’t know if I can trust in the medical system behind me: for the receptionist at the front desk to treat her with dignity, for the line at the psychiatric emergency room to not be out the door, for her to feel trust and compassion from the doctors and nurses she feels, for the system to have a detox bed to which she can go. I try to reassure her as best I can and quell my own doubts about the system.

With Lydia, I struggle to think of the clinic as a “safe” space for her. As a future physician and an anthropologist, I want to believe that the clinic can be a force for good by necessity of my own choice to work within its confines. Yet can it truly be a means to addressing structural violence in Lydia’s life? She left and she did not return. How can the clinic possibly

address Lydia's anxiety and despair? Can the clinic put an end to Lydia's enmeshment in the carceral system that now poses the most "risk" to Lydia's opportunities for well-being? I am not sure. Why do we think the clinic can be a space for social justice?

Finally, I learn that Lydia did in fact make it to the community clinic's urgent care center and that she was sent by ambulance to the emergency room at the main hospital. She stayed two weeks in the psychiatric inpatient unit, detoxed with a relatively humane methadone protocol and was eventually set-up to go to the Barbara McGuinness House, a shelter for medically complicated homeless individuals. Perhaps Lydia is finally on her way out of the institutional circuit. Or perhaps the streets will subsume her and she will be back to her life of dope and despair, doing what she knows best?

Illicit Drug Use and Governance of the Sick and Poor

From a biopolitical perspective, the question remains about whose bodies are the sites of positive forms of intervention/optimization, and whose bodies are the sites of negative intervention or lack thereof; it seems that not everyone is at risk for the same sorts of interventions in the name of health. Why is the terrain of biopolitical schemes so uneven in which women like Lydia seem condemned to a life of suffering and despair? Are those who are "let die" the individuals who cannot or do not "exercise biological prudence, for their own sake, that of their families, that of their own lineage, and that of their nation as a whole" (Rose 2006:24), or those who are marked as dangerous, morally unsound or biologically risky for the population as a whole? The bodies of addicted women have historically been seen as a site for social intervention in the name of the good of the social body (Campbell 2000) as is evident from recent news that a non-profit organization sponsored by a right-wing billionaire was offering voluntary sterilizations to female drug addicts for \$300 (Lee 2010). What are the implications of

such forms of intervention for women who use drugs and who are only becoming more tenuously connected to the polis? How do people like Lydia become marked by our state institutions as the most deviant, the most aberrant, or the most morally suspect and come into regimes of knowledge and discipline; what is the value of the lives of the poorest of the poor? How, and in what ways, is their suffering and illness part of a scheme of governance of life itself?

Foucault defines “biopolitics” as “the endeavor, begun in the eighteenth century, to rationalize the problems presented to governmental practice by the phenomena characteristic of a group of living beings constituted as a population: health, sanitation, birthrate, longevity, race...” (1997: 73). The population itself became constituted as an object that could be known, quantified by various measures and intervened upon as a form of governance. The new right of modern power was the “power to ‘make’ live and ‘let’ die” (Foucault 2003: 241), although significantly, it did not supplant the traditional power to “take life or let live” but, rather, combined with it in complex and historically variable ways. Medicine (and the increasingly effective therapeutic armamentaria that medicine was able to draw upon), in combination with the flourishing of biological sciences and the science of population and disease identification and mapping, was critical to enabling this shift to modern power.

It is worthwhile examining why Foucault thought that life had risen to such a central place of prominence in modes of governance. Why did the “physical well-being, health and optimum longevity” (1980: 170) of a population of people come into such sharp focus as important political objectives? The obvious answer is that healthy laboring bodies could both fight for and work for modern power. Bodies, now known in all their varieties and kinds, could

now be acted upon as sites for intervention, useful for the production that capitalism demanded of its populations.

But this new concern with population allowed for finer and finer distinctions; interventions by the state would occur not only on those who were thought to be “more utilizable,” but on all bodies to greater or lesser degrees. Foucault traces this change specifically when he charts how the needs of the “sick poor,” which had previously been relegated to the charitable associations, became a central concern of the State itself. The poor, the disabled, the elderly, the sick and the infirm had previously been cast aside as within the domain of religious charity; in a biopolitical framework, they were now critical to a scheme of governance and poverty management. While they were not those who might be optimized into a state of health and the ability to work, they were nevertheless part of explicit calculations and interventions. As Foucault writes:

This analysis has at its practical objective at best to make poverty useful by fixing it to the apparatus of production, at worst to lighten as much as possible the burden it imposes on the rest of society. The problem is to set the ‘able-bodied’ poor to work and transform them into a useful labour force, but it is also to assure the self-financing by the poor themselves of the cost of their sickness and temporary or permanent incapacitation, and further to render profitable in the short or long term the educating of orphans and foundlings (1980: 169).

While the poor themselves could not be useful, attending to their “poverty” could perhaps be made useful by binding it up with an emerging capitalist system; the contemporary prison system has become indicted as a system profiting off the inevitable poverty of the poor (Wilson 2007; Christie 2000; Burton-Rose and Wright 2002; Feeley 2002). Biopolitical schemes entailed “economically rational” and universalizing mechanisms of dealing with the poor (such as

insurance schemes) rather than the previously “indiscriminate” and “patchy” system of religious charity (2003: 244).¹¹⁸

What matters for a biopolitical analysis is that addicted women seem to comprise a particularly “problematic,” expensive, and dangerous sub-population in which some bodies were to be neutralized while some bodies were to be optimized. The poor and the sick, who were potentially never able to be useful, were seen as sources for potential contagion, danger, and moral contamination—in other words, “internal dangers” (Foucault 2003: 249)—to the rest of the population. New distinctions among a population that had been known as paupers were made under a biopolitical framework; “paupers” were now subdivided into “the good poor and the bad poor, the willfully idle and the involuntarily unemployed, those who can do some kind of work and those cannot” (1980: 169). These distinctions inevitably carried a moral valuation, as they do with addiction, and would become another means through which interventions were justified.

A Politics of Un-Belonging

Foucault was vague about what axes of inequality and markers of individual difference would become the grounds for intervention on the population. What were the factors that determined who would be subject to interventions to optimize the length or quality of their lives,

¹¹⁸ Foucault discusses several objects of biopolitical intervention in “Society Must Be Defended,” including natalist policy, epidemics, endemics, and the environment. These all were problems falling within the scope and purview of biopolitics. Endemic disease was increasingly important because it “sapped the population’s strength, shortened the working week, wasted energy, and cost money, both because they led to a fall in production and because treating them was expensive” (2003: 244). Some of the specific problems of endemic disease included those of old age, general enfeeblement and disability; they all were important because they had “similar effects in that they incapacitate individuals, put them out of the circuit or neutralize them” (2003: 244). From a population point of view, these individuals were seen as critical weaknesses; thus, their problems had to be dealt with head-on.

Many have considered addiction to be a disease “endemic” to modern societies. As the writer Aldous Huxley once observed, as long as people lived in poverty, drug use would be inevitable: “That humanity at large will ever be able to dispense with Artificial Paradises seems very unlikely. Most men and women lead lives at the worst so painful, at the best so monotonous, poor and limited that the urge to escape, the longing to transcend themselves if only for a few moments, is and has always been one of the principle appetites of the soul” (1954:62).

on the one hand, and those others who would be subject to interventions to keep them at bay or to neutralize or minimize the potential dangers or costs they imposed on everyone else? Clearly economic utility was part of this calculus, but Foucault was unclear about how notions of difference, degeneracy and contamination led to specific interventions (recall Lydia's desire to a be "productive citizen" once again). His most clear treatment of the idea of difference was within his discussion of racism. As he writes in "Society Must Be Defended," "What in fact is racism? It is primarily a way of introducing a break in the domain of life that is under power's control: the break between what must live and what must die" (2003: 254).

What is critical here is the way in which social and political categories and hierarchies of distinction – class, sexuality, gender, to name a few—become seen and known as categories within a biological domain or purview. It is this finessing and intercalation of socially constructed domains into what appears to be "biological" that is critical, thus paving the way for the masking of the political aspect of social relations under the auspices of "the elimination of the biological threat to and the improvement of the species" (2003: 256). In fact, Foucault links racism directly to the state in that racism gives the state the moral justification to "foster life" or "disallow to the point of death" (1978: 173). Foucault elaborates that when he speaks of death and killing, "I obviously do not mean simply murder as such, but also every form of indirect murder: the fact of exposing someone to death, increasing the risk of death for some people, or, quite simply, political death, expulsion, rejection, and so on" (2003: 256).¹¹⁹

¹¹⁹ Giorgio Agamben's work on bare life—and the "life that does not deserve to live"—would be a useful juxtaposition of Foucault's idea of indirect murder here. Agamben's interpretation of "the age of biopolitics" entailed power having the right to "decide the point at which life ceases to be politically relevant" (1998: 142). Agamben wonders about the concentration camp as "the space that is opened when the state of exception begins to become the rule" (1998: 168-169). Is the prison the modern day camp? This question demands its own separate future analysis.

Didier Fassin also notes that Foucault did not talk about inequalities within the politics of population, or as he puts it, “deciding the sort of people may or may not live” (2009: 49). As he argues, the terms “biolegitimacy and bio-inequalities tells us much about the meaning and values we attach to life as such and to lives concretely” (2009:49). He asserts that using the term biolegitimacy allows him to think about not the forms of governance and means of power itself but rather about what moral valences and judgments are involved in the process: “It is moving from the ‘rules of the game’ to its stakes” (2009: 52).

What is critical here is the way that incarceration is a means of “exposing someone to death” *en masse*. The drug addict is the quintessential “anti-citizen” who is bared to suffering and death (Rose 2000). As Nikolas Rose writes, “Anti-citizens,” also known as “non-citizens” or “failed citizens,” are “comprised of those who are unable or unwilling to exercise their lives or manage their own risk, incapable of exercising responsible self-government, either attached to no moral community or to a community of anti-morality” (2000: 331). Instead of illness as a means to gain political and legal recognition as in the case of post-Chernobyl Ukraine that medical anthropologist Adriana Petryna (2002) has documented, addiction is a means for government intervention on bodies that furthers the loss of political, civic and legal forms of recognition, perhaps effectively disallowing the potential for well-being and for life itself.

Lydia’s story illustrates some of the specificities and messiness: the fault lines along which we decide whose live matters and why, as well as the consequences and complexities of living various forms of political, social and civil deaths after hospitalization and jail. Many facets of her identities are means for intervention, discrimination, and social rejection: her transgressive gender non-conforming fat body, her poverty, her perceived idleness and immorality, her

criminality, her self-injurious behavior. She therefore dwells in a space that Judith Butler (1993) has called the “abjected outside,” that is, “those ‘unlivable’ and ‘uninhabitable’ zones of social life which are nevertheless densely populated by those who do not enjoy the status of the subject, but whose living under the sign of the ‘unlivable’ is required to circumscribe the domain of the subject” (3). Butler argues that such subjectification constitutes the subject “through the force of exclusion and abjection” (ibid.) and becomes internalized and constitutive of one’s character and being.

In Lydia’s case—her alternating casual and despairing attitudes toward living and dying— were intensely shaped by the despair she felt upon being released from the hospital’s surgical service back to a rooming house full of fellow heroin addicts. Lydia’s experiences after discharge from the hospital demonstrate the failure of our healthcare system to treat the “social determinants of health,” that is, her addiction and her housing situation, which were two obvious and well-documented facts in her medical record. Like me, she understood the hospital as partly to blame for her return to active addiction given the under-treatment of her pain and the lack of support provided to her upon her release. There was no mention of her distressing social circumstances, a state of everyday violence (Scheper-Hughes 1993), the violent aftermath of either her release from the hospital or her earlier release from prison.

While hospitals strive to get people to a better state of health than when they first arrived, there is no metric of success or accountability regarding hospital stays and discharges and returns.¹²⁰ This hospital in particular could be congratulated for providing excellent clinical care: they had saved her life by accurately diagnosing the early warning signs of necrotizing

¹²⁰ Medicaid established a payment system in October 2012 to penalize hospitals under the Affordable Care Act that re-admitted too many “frequent flyers,” that is, patients that were re-hospitalized constantly for conditions that should have been addressed during the patient’s initial hospitalization (see Stone and Hoffman 2010).

fasciitis and giving her the appropriate and necessary treatment. During her stay in the Surgical Intensive Care Unit, they gave her medications to keep her blood pressure up while she struggled on the brink of septic shock. They performed all the necessary measures to keep her alive. Was it the hospital's fault that Lydia lied, that she said she had a home? Was it their fault that she rapidly became homeless again and resumed drug use? Does Lydia's life history and her clinical situation make her deserving of life itself, but not a quality life? Is her tarnished moral personhood, her status as an injecting drug user, the reason that she does not deserve full health?

Perhaps this is why Lydia was sent "home" to the streets to take care of herself, in the context of modern hospital payment schemes that cannot factor her distress into their calculus of deservingness and worth. She subsequently endured a ceaseless anxiety over her precarious social situation, one that I thought was bordering on mania. This anxiety, despair about her circumstances, and her ongoing depression and loneliness were directly brought about and shaped by institutional processes and outcomes related to her hospitalization and her previous incarcerations. She once told me, "I'd give anything to have my boring little neat life back."

Having been incarcerated also greatly shaped Lydia's subjectivity and her ongoing sense of being in the world. When she first got out, she felt compelled to "party" in order to acknowledge and seize her newfound freedom, to exert her relative agency in a world in which she is generally assumed to be powerless. Being incarcerated had given her time to think about her life and her decisions, but it had also taken her temporarily out of the game of life. As she put it, "In jail, I kept contemplating whether I was going to go back to [drug dealing and robbing drug dealers] and you want to know what's crazy... I'm still breaking the law [by doing drugs]! I'm like, well at least I ain't breaking the law by stealing out of stores, and robbing, and I don't rob your average fucking person."

Lydia could not turn to her family to provide her shelter from her dangerous life on the streets. Her immediate and extended families were rife with addiction and trauma that is all too common to low-income families. Lydia's biological father was a bank robber, and when they hung out together, "I picked up his bad habit of becoming institutionalized" and as a result spent the better part of "2006-2009 in and out of jail." One of the cousins that she was particularly close with, in what was thought to be a paranoid psychotic break, had raped and killed his mother. One of her girlfriends had been murdered in 1995, and Lydia felt traumatized from that incident. Her sister also had become a heroin addict and had histories of overdose and stealing from the family. Lydia also alluded to her mother's prescription opioid and benzodiazepine use. Her tight-knit Italian family was breaking apart at the heavily-worn seams; they do not and cannot provide each other the kind of "care" that Angela Garcia (2010) writes about in her study of heroin addiction in Hispanic families in New Mexico. Lydia's mother would not even let her come back home even after her hospital stay, encouraging her to go back to the hospital.

Lydia's story illustrates the social complexity of what historian Michael Ignatieff (1984) has called "the needs of strangers." How can we articulate and call for what will Lydia perhaps desires most: dignity, respect, equal footing in our human community? She certainly needs these intangibles just as much as she seeks out physical health. Ignatieff hopes to imagine a different sort of social compact; as he writes, "It is because fraternity, love, belonging, dignity, and respect cannot be specified as rights that we ought to specify them as needs and seek, with the blunt institutional procedures at our disposal, to make their satisfaction a routine human practice" (1984: 13-14).

Yet is the state what will bring about a new ethic of caring? What does it reflect about our moral community and our participation in the social order that the state we hold up both punishes

and assists the less fortunate among us? Is it possible to imagine a different social compact where the hospitals and the prisons are not seen as central components of public safety, law and order and well-being? In Lydia's case, they have doled out many civil deaths and ongoing sorrow. Her treatment is harsh and she consequently limps along in death-in-life. One of the saddest ironies is that she believes that this suffering is ultimately her own fault, a by-product of her diseased brain just doing what it always does: "A big part of me is like stay sober, stay sober, I want to get my life back. I worked all my life, and just in this little seven years... I don't know how I'm getting my life back. Want to, want to, want to, but want to get high."

Chapter 8: “Recovery Is My Job Now”

“I tried to get all kinds of different jobs. ‘You’re not exactly what we’re looking for.’ You have to fall back on what you know. For me, that was hustle, whichever way I had to do it. [Selling] pharmaceuticals, like klonopins. I had to change with the times[shift to pills].” -Linda

"Works well in a high-pressure environment. Self-motivated and assertive. Enjoys working with people." These are some of the character and personality traits that Serenity has listed on the resume that she is writing in jail; she is particularly proud that she has typed it up herself on one of the jail's three PC computers. This is only one part of her overall “recovery” plan: the rest of her agenda items include going back to school to become a registered nurse, actually following through with contesting the denial of her Supplemental Security Income application (SSI) and getting her own housing. She admittedly has a sparse work history, with no formal work in the last ten years since she moved to Boston and has been dealing with heroin addiction and homelessness. She lists her previous work experience as “broad experience as licensed nursing assistant with certification in CPR.” She also lists her experience working at a coffee shop in New Hampshire. Makes dough, handles the fryer.

Her resume—like all resumes do—tells a certain story about our lives that smoothes over the gaps, the holes, the time periods of emotional turmoil and interpersonal angst. In her case, the resume sails over the time that she lost her job because she started using too many drugs and was unable to get up in the morning to go to work, the time when her personal house-cleaning business languished as she became more interested in scoring dope. It glosses over the twenty times that she has been in and out of prison and jail, but then again, any potential employers will find that out soon enough. Her Criminal Offender Record Information (CORI) is “a mile long,” according to her, although she admits that she has not actually seen it recently.

It is also true that Serenity works well in a high-pressure environment—the streets of downtown Boston. The cobblestoned and bricked streets are so charming, even quaint in their unevenness, yet they are also full of temptation, danger and heady uncertainty as she plies her other trade, her more regular form of income-generation between the hours of 4AM and 7AM. Sex, it always sells. When she doesn't want to resort to prostitution—which she increasingly doesn't as she gets older and more weary—she buys drugs in a small bulk quantity and flips them in order to have enough for her own use. She is industrious in her penury and lives from week to week, from fix to fix.¹²¹

Serenity is not alone in her industrious poverty, even though she is a drug addict. She belongs to a wider class that sociologist Herbert Gans has called “the excluded poor” and also “the blamed poor” (Gans 2009) and that historian Michael Katz (2013) calls the “undeserving poor.”¹²² These are the poor that are responsible for their penury; they are able-bodied and could and should work and their poverty is a product of their own making. //Nor is she alone in experiencing the insistent societal emphases urging her to get a job even though the job market has largely prohibited her entry except into its lowest, most undesirable rungs. The risks of incarcerating an ex-felon, especially in a nursing home or a hospital where she so hopes to be, are just too high. The sense of potential danger, the unreliableness, the financial liability, it all is too much to stake on her.

¹²¹ In *Off the Books*, urban sociologist Sudhir Venkatesh (2009) argues that the “informal” and “formal” economies are necessarily linked and depend on each other as people who live in poverty move fluidly in and out of both kinds of income-generating activities.

¹²² Gans writes of the excluded poor to emphasize “their being virtually completely left out of the formal economy and therefore out of the polity and mainstream society as well” (2009:80); he uses the term blamed poor also “for they are often condemned for their own poverty and exclusion by failing to follow the rules of mainstream American culture” (2009:81). Katz writes that the “deserving poor” include “children, widows, and a few others whose lack of responsibility for their condition could not be denied,” while the “undeserving poor” are those who “have been thought to have brought their poverty on themselves” (2013:3).

Serenity knows this all too well, even though she can glibly speak of her “career goals” and work ambitions to any concerned drug treatment administrator or program staff for the jail. When she leaves jail and she is released straight from the Boston Municipal Court on New Chardon Street, she does not report to probation (immediately setting herself up for re-incarceration by violating probation if she gets stopped by a police officer). She does not enact the plan that she has labored over in jail to go to a drug treatment program, to look for housing, or to start a tedious, possibly even fruitless, job search. Instead, she goes to her best friend’s house, smokes crack and then heads out to find dope to come down off of the frenetic crack high.

Finding work is one of the last things on her mind when she steps out of the courthouse and takes in the humid air of Boston summer, but the notion of work has been planted there by our cultural orientations towards work, by the administrators and program officers at the jail in the classes that emphasize self-reliance and pulling oneself up by one’s bootstraps.

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I was struck by the importance of working—or lack thereof— among women leaving prison when I had a meeting with several men from a local organization, Ex-Prisoners Organizing for Community Advancement (EPOCA) based out of Worcester. They were in the early stages of a campaign addressing the “collateral sanctions” at the Registry of Motor Vehicles (RMV) to modify a \$500 driver’s license reinstatement fee for anyone who had been convicted of a drug-related felony (not necessarily just those committed in vehicles like DUIs). They argued that the RMV also had a second version of one’s criminal proceedings, what they called a “back-door CORI” that can never be sealed, which harms a person’s chances of employment even decades after the fact.” In the advocacy group’s opinion, it was an unfair and stigmatizing barrier to getting work, since getting a driver’s license back was so key to getting to

and from a job. It dawned on me as we were talking about the campaign that this seemed to affect none of the women that I had met in prison or largely even in the community.

I wondered why this was this not an issue for women leaving prison as much as it was for men leaving prison. I knew from working with many of the women that they didn't have their drivers' licenses, so why weren't they concerned about getting them back, about the implications for getting a job? I realized there was a distinctly gendered dimension to life after prison, to looking for work, to this question of labor. Why did the labor market not seem to be a generative space for meaningful life experiences among women with histories of incarceration?

Getting a job is difficult, if not impossible, for women with histories of recent incarceration. Only two of the thirty-odd women in my study held any kind of job in the formal labor market during my fieldwork; both women were recruited from the community cohort—one had a prior history of incarceration and worked in telemarketing part-time for three months before she quit due to the high prevalence of drug use in the office, and the other had no history of incarceration and was working full-time at Walgreens. Most of them were not actively looking for work, although they often talked about it vaguely as something for the future. Yet I noticed there was substantial effort and focus on getting women in prison to get back to work. This seemed like an important disjuncture between the rhetoric and programmatic efforts of the Department of Corrections and the lived experiences of the women I came to know.

The Work of Prisons: Putting Women to Work

In the sociological and policy literature on employment after incarceration, there is an epistemological orientation that affirms that work is a generally positive and stabilizing force in people's lives—in other words, that work provides a necessary sense of daily rhythm and life structure. Criminologists emphasize the benefits of what they call “strong labor force

attachment” leading to less “anti-social behaviors” (Piehl 2003; Hagan 1993); they argue that decent jobs with some level of stability and prestige can reduce recidivism (Sampson and Laub 1993; Uggen 1999).¹²³ A report on women, incarceration and work sponsored by the Women’s Prison Association posited that “employment can be an integral part of a self-sufficient and independent life” (Rose et al. 2008:5).

Work is a strongly moralizing trope in American culture; it is part of what it takes to belong to our social compact, after all. Where we work and what we do shape our core identities, our sense of ourselves and self-esteem, and even our ways of being-in-the-world. Sigmund Freud wrote that work was a way of “fending off suffering” as well as “a path to happiness” (Hawkins 1983: 85); work was also an essential stabilizing anchor to ensure that individuals felt belonging with a community of others.

Questions of work and labor are central to philosophical notions of the good life and the good society. We as humans must be able to find meaningful work and feel be adequately compensated for such activity. The Universal Declaration of Human Rights includes work in Article 23: “Everyone has the right to work, to free choice of employment, to just and favorable conditions of work and to protection against unemployment” (United Nations General Assembly 1948). There is also an emphasis on the ephemeral notion of dignity: “Everyone who works has the right to just and favorable remuneration ensuring for himself and his family an existence worthy of human dignity, and supplemented, if necessary, by other means of social protection.”

Work is therefore somehow inextricably linked to leading a dignified life, one marked by one’s contributions and ability to provide support for oneself and one’s immediate family (see

¹²³ In sociology, strain theories (Merton 1938; Agnew 1992) say that those who work after prison will feel less strain or tension between one own behavior and dominant social norms, decreasing the likelihood of re-offending, while the social bond theory of crime (Hirschi 1969) argue that individuals will engage in conventional life experiences such as marriage or employment, forming positive bonds and attachments to others, meaning that more is at stake for engaging in future crime.

Nussbaum (see Nussbaum 2000 for an expansion of Amartya Sen's capabilities approach to think about the lives of poor women). Work affords us a sense of identity and a way to move forward and proceed confidently in the world—what psychologists call “self-efficacy”—that is, the perception of one's own ability to face challenges and succeed in goals.

Those who cannot or do not work tend to face stigma and pejorative moral judgments. As Lawrence Yang and colleagues have written, “Violation of these core values leads to moral sanction; such individuals are cast as the moral “other,” in accordance with American values that Alexis de Tocqueville had observed that labor was “the necessary, natural and honest condition” and that work was “held up the whole community to be an honorable necessity” (Yang et al. 2007 1529).

One strong and commonly held sentiment towards people that use drugs is that they are weak-willed, lazy and do not work by choice even though they could. This cultural orientation believes that drug users (and the poor more generally) profit from the rest of the laboring public's tax-dollars and productivity by “gaming the system” through various government assistance programs. In a report produced by the American Bar Association in 1957, drug users were urged to “convert their ‘undisciplined lives’ to ‘clean, honest, temperate and industrious lives’” (Campbell and Ettorre 2011:32). Loic Wacquant posits that we punish the poor with incarceration “if they prove too recalcitrant and disruptive” and are not successfully “steer[ed] ... toward deregulated employment through moral re-training and material suasion” (2010: 83).

Work, therefore, is not surprisingly seen as critical to the reformation of deviant criminals. The iconic Eastern State Penitentiary in Philadelphia two centuries ago was founded on the Quaker and Progressive ideologies that prayer and work would lead to salvation and rebirth for the criminals within; while incarcerated, men would work for hours in isolation and

silence. Gustave de Beaumont and Alexis de Tocqueville, in their tour of the early American landscape, recommended this model for prisons in France; as social historian Caleb Smith writes, “The important thing, for them, was that solitude should be mitigated by labor. Prisoners were tormented in their idleness by guilt and loneliness, but ‘labor, by comforting them, makes them *love* the only means, which when again free, will enable them to gain honestly their livelihood” (2009: 67).

Yet the notion of getting incarcerated women to work upon release from prison is a relatively newer phenomenon, reflecting changes in the past several decades in both the gender composition of the formal economy and conservative political ideologies against perceptions of dependence of the poor on the state.¹²⁴ Women were initially thought to not have the mental capacities for logic and reasoning that were crucial to early notions of prison rehabilitation; as legal scholar Francis Lieber wrote in the preface to Beaumont and Tocqueville’s report, “The two sexes have been destined by the Creator for different spheres of activity, and have received different powers to fulfill their destiny. The women destined for domestic life, and that sphere in which attachment and affection are most active agents” (Smith 2009: 211).

Poor women in prison systems, therefore, were oriented not toward the labor market but rather toward the proper fulfillment of domestic duties. Early prisons for women, like MCI-Framingham, necessitated a uniquely gendered kind of prison rehabilitation scheme. Relatively lengthy sentences of two years for petty crimes related to ‘public order’ violations were meant to provide “ample time for character retraining, while an indenture program offered women the

¹²⁴ Philosopher Thomas Scanlon epitomizes this orientation when he writes that “all forms of State support are founded on erroneous conceptions of the relation between the State and the individual. It is the duty of every man to make provision for himself and for those dependent on him; and of the State to see that no obstacles hinder his doing so. Where the State does more, or the individual less, there is nothing but disaster in store for both” (Garland 1985: 45).

opportunity to earn money and learn domestic skills as dayworkers in nearby households” (Freedman 1996: 186).

There was significant anxiety and commotion about the day labor indenture program in 1930s Massachusetts. The progressive superintendent of Framingham, Miriam Van Waters, came under fire for allowing incarcerated women to do work. The superintendent argued she wanted women to be able to be financially independent from men; she pointed out the inequities that “men but not women could earn money for prison labor in Massachusetts, and only men received state funds upon release. Commissioner Lyman had agreed to give women release money, but only three dollars, compared to men’s eight to ten dollars” (Freedman 1996: 257).

Yet interestingly, women were allowed to labor at the prison-based industries; at MCI-Framingham, there was for decades a flag-making industry. The state-run prison labor industry (slogan: “Working on the Inside; Succeeding on the Outside”) still exists in the form of MassCorr Correctional Industries, netting \$10.8 million in revenue in 2005 (Kelly 2009). A division of the Massachusetts Department of Corrections, the stated aim of the prison labor program to instill work discipline and prevent recidivism:

The mission of Correctional Industries is to instill a positive work ethic in offenders by providing training and skills for a successful reentry into the community through work opportunities, while ensuring the highest level of customer service by providing a quality product at a competitive price. Through work assignments offenders develop occupational skills and discipline that enhances successful reintegration. With acquired on the job training and work ethics gained through Correctional Industries, released offenders have a greater chance of being gainfully employed and succeeding after their release (Spencer 2013).

The labor of poor women now is an area of distinct emphasis in the programming of contemporary prisons and jails. Notions of domestic training and preparation for a life as a proper mother and wife are largely subsumed within courses on parenting or “criminal thinking.” I found that the South Bay House of Corrections focused intently on the employment angle for incarcerated women in addressing recidivism and reentry. They had recently received a grant in

partnership with Northeastern University to start a career center in the jail for anyone who was interested (not just the women). I spoke with one of the staff members at the women's programming department about the difficulty of employment prospects. She told me she wanted to make going to resume class or the career center as normative as it was to attend parenting, domestic violence and GED classes. She felt that it was generally unrealistic to expect that the women would largely be stable enough to work upon their release, but she felt that even if the career center benefitted five women, who were at least partially employable, then it would make the program worthwhile.¹²⁵

In the MCI-Framingham New Horizons Center (the re-entry resource room for the prison), a poster on the wall proclaimed, "Dress for Success." It showed a cartoon of a black woman wearing a DOC prison jumpsuit looking at a mirror image of herself and seeing the same woman smiling back at her wearing a red dress with a snazzy belt. Another sign in the room read, "Success in an interview": the pie chart underneath read "45% packaging, 35% responsiveness, 10% experience, 10% miscellaneous."

The terrible irony of doing employment work, or engaging women in prison about getting jobs more generally, is that the fact of being incarcerated in and of itself is a modern day scarlet letter on the career opportunities for poor women. Similar to the new focus on trauma, the focus on getting women leaving prison to look for jobs sidesteps the fact of incarceration itself. Sociologists have carefully examined the effects of the mark of a criminal record (Pager 2003; Western and Pettit 2005; Holzer, Raphael, and Stoll 2003; Western, Kling, and Weinman 2001);

¹²⁵ The jail also had hosted prior mock-career fairs in which employers from the "outside" would come and women dressed up and acted as if they were applying for jobs. None of the employers were offering "real" jobs and as far as I know, none of them resulted in the promise of a job upon release. It was "playing" at getting a job. Several of the women enjoyed the "realness" of the event.

they have furthermore found a compounding effect, that is, that being black in addition to having a criminal record is a doubly precarious for one's chances at employment.

In Massachusetts, partly in response to the employment difficulties of people leaving prison, activists initiated a campaign around CORI reform known as "Ban the Box." The CORI is a government document that is provided to all potential employers containing a person's criminal history, including any charges that were filed in state or federal court as well as the outcome of the case (guilty, not guilty, dismissed, etc). The purpose of exchanging such records is in the name of "public safety," that is, there should be full transparency of one's criminal justice involvement in the hiring of potential employees. Yet advocates for CORI reform argued that the CORI effectively allowed for discrimination of individuals based on previous criminal justice involvement; in 2010, they succeeded in passing several minor reforms signed by Governor Deval Patrick, the most significant of which was to exclude the criminal justice involvement question from the initial job application ("banning the box"), although employers could inquire about it later in the application process. CORI reform also reduced the time when felonies and misdemeanors could be "sealed"—that is, erased from the CORI with a clean record (sealing a felony conviction went from 15 years to 10 years and a misdemeanor went from 10 years to 5 years). And ten years is still a long time to see a CORI.

I spoke with some of the groups that had been involved in leading the CORI reform effort. I wondered about why it seemed like so few of the women in my study had mentioned having difficulties with their CORI. I realized that the majority of them were not actively looking for jobs. Of the ones that were, their job search seemed like they were shooting at the moon. They tended to be unable to navigate the necessary multitude of intangible steps involved in looking for, getting and maintaining a job. Nor did they particularly want to step into that fray.

Working on Women's Work Readiness in the Jail

In prison, I discovered that having stable or full-time jobs in the formal economy was usually absent from the life histories of incarcerated women. Several of my interview questions involved work. I discovered that the majority of the twenty women I met in prison and jail had life histories of seasonal, part-time, or off the books jobs. Most of them had not worked formally in the past five years or more. When I asked them what they had wanted to be when they grew up, most of them answered right away without hesitation. They had wanted to be doctors, nurses, veterinarians, and lawyers or advocates for children in difficult circumstances like their own. Not surprisingly, none of them were able to achieve these professions; only approximately half of them had completed GEDs or high school diplomas.

The jobs that they had actually been able to land were more typical of the sub-proletariat or working class “pink collar” industry: hairdressers, medical assistants, billing, sales, receptionists, retail stores like the Gap, housecleaning, and nannyng (only five of them had significant career histories before they fell into drug use and subsequent unemployment—Lydia as a pharmacy technician; Diane as a unionized construction worker; Susie as a billing assistant; Serenity and Mary as certified nursing assistants). The jobs they hoped to do in the future were mostly defined by life experiences they had had more recently than holding down formal jobs: the majority of them wanted to become certified alcohol and drug counselors. They saw it as a field in which their existential experiences—having lived through and struggled personally with addiction—might actually be seen as a job asset, not as a detriment. Many also aspired to re-join or newly train in jobs in the medical field, like Serenity, who aspired to be a registered nurse (RN). Many hoped they could be phlebotomists since they knew their way around veins and

could manage to hit scraggly, shrunken veins on themselves and across a variety of bodily terrains.

It struck me as difficult, if not impossible, for these women to achieve their dream occupations given their general levels of trauma, untreated mental illness and addiction in combination with the failures of a class-based educational system that could not counteract the persistent forces of intergenerational poverty and societal oppression. If these women are lucky and extremely driven, they will be allowed back into the world of the female service industry that is marked by menial, low-paying jobs with no serious upward mobility and that largely do not produce meaningful new social relationships or life experiences.

Rationally, many of the women seemed to be turning away from a labor market that systematically excluded and disempowered them. In order to better understand women's relationships with the labor market, I turned to an organization called Project Place in the South End neighborhood of Boston. Project Place has a long history of working with incarcerated populations specifically around employment. According to their website, they describe themselves as "a supportive community that promotes hope and opportunity for homeless and low-income individuals by providing the skills, education and resources to obtain stable employment and housing."

Project Place is home to a well-regarded program called CREW (Community ReEntry for Women) that has won numerous awards and accolades for its re-entry work with the Suffolk House of Corrections. Recently, the CREW project was named a 2012 "Bright Idea" by the Ash Center for Democratic Governance and Innovation based at the John F. Kennedy School of Government at Harvard. The city's longest serving mayor of Boston, Thomas Menino, who served five terms as mayor, said that the Project Place organization literally cleaned up the

human detritus of Boston with its work: “Of all the programs we do in this City, Project Place is my favorite because it really does make a difference. It helps clean up the city. It also helps clean up people’s lives.”

The CREW team is based at Project Place in the South End but it also sends staff members into the Suffolk House of Correction to run CREW classes on employment and job readiness. I met Polly Hanson, the program director of CREW, at the modern, capacious Project Place building on Washington Street in the South End almost where Chinatown begins. She is a bubbly white woman with curly hair and glasses whom I have met several times before through semi-regular meetings of the Female Offender Mental Health Re-Entry Task Force arranged by the Suffolk House of Corrections staff.

Hanson told me about the evolution of the CREW program, which began in 2007 out of a Department of Education grant focused on job readiness for women. In the beginning, they had to adapt the program to the realities of women’s lives: “[We] learned pretty quickly that we had to back things up a couple steps to get women prepared to even think about the process of looking for work, so, really addressing self-confidence and just self-conception, and frankly even a belief that work is possible.” The class then started with four weeks of “life skills” and then four weeks of job readiness; this morphed into six weeks of “life skills” and then two weeks of job training. They try to help women deal with the complexities of their lives and life after prison by teaching them coping skills and how to make good decisions. Another key part of the CREW program is they want women to come to CREW in the South End when they are released to take advantage of “wrap-around services.” Project Place hopes that they can provide women with ongoing case management, employment opportunities, and housing help, among other things that

women might need. They want to be a “one-stop shop” for women leaving prison although it works better in theory than in practice.

Hanson noted that the CREW program had to bring the women down out of the clouds and back to the realities of their lives, trying to reconcile what women wanted to do for employment in a perfect world with what kinds of jobs they might actually be able to get: “Everybody wants to very much go into care-taking roles and definitely the medical profession. And it is very challenging especially for women who have CORIs, and especially if they are specifically related to intravenous drug use... you can’t be a phlebotomist. It’s not going to happen, you know.” Hanson faces an uphill challenge because she has realistic appraisals of women’s fairly dismal job prospects: “How can it be something that’s not working at Dunkin’ Donuts that feels very dead-end and then you hit your limit and it’s like well, it’s easier to just not work.” Or, I added, they can make more money standing outside the Dunkin’ Donuts than standing they can at the cash register.

Hanson puts forward the sociological argument that work is a stabilizing structure and provides an orientation to people’s lives. She knows that getting a job is low on the list of priorities for women leaving prison, but she argues that it just as good as any other place to intervene (housing, mental health/medical care). Amidst these competing rationalities towards well-being after leaving prison, Hanson tries to emphasize that getting a job could be good even in the context of life stressors: if you get a job, then you don’t have to spend as much time at that drug treatment sober house that you hate! But she also understands, as she puts it, that “psychodynamically”-speaking, that it’s a bit more complicated for women who use drugs and have been incarcerated. She explains:

People [are] taking opiates to ... disconnect... It’s antithetical to being like, I’m going to dive in, get up at seven, and I’m going to go be in the world. Because I’m removing myself from the world [by doing drugs] and so there’s so many things that come up that are about removing but then that

removal breeds depression, isolation, and then it becomes this cycle. But if you try to clear up the haze, and you try to connect or stay present, you are overwhelmed by all the packed down trauma and pain that everybody's been avoiding the whole time.

It is precisely not being a part of the world that women who use heroin seek to achieve, to achieve a sense of distance, dissociation even oblivion. Employment is one angle to approach the re-entry of women in prison, but as Hanson and the CREW project realized, it is just one vantage point from which to peer into deeply troubled lives. The issue of trauma kept bubbling up to the point of even detracting from their main goal of talking about “employment readiness” and re-entry. Hanson elaborates the difficulty that trauma poses for their program: “A huge part of the curriculum is trying to develop a new identity or patterns that might be related to the histories with trauma. I have actually encouraged us to do a little less into delving into, because I think it's too destabilizing and I think it takes away from building the skills to cope, so I'm actually trying to do more identifying red flags and building coping skills tool-box kind of thing, because they're all too aware of their trauma in so many ways, and it's uncontained...”

The concrete changes they made after Hanson's suggests to do less “delving into” included taking out the week on parenting—that is, looking at how they were parented and how they themselves parent. Too much “stuff” kept coming up. Hanson conceded that “[trauma is] coming out every pore of so many of the women that containing it is more than a full-time job and it's very hard for them.”

Hanson noted that of the women who took part in CREW, 33% were able to get some kind of job, although it is not clear how long or how many of them managed to keep them. The majority of the women did not take up the Project Place offer to work part-time there and train in the “food service” or “facilities maintenance” enterprises that were offered to them (interestingly, men were much more likely to do these programs). I think of Hanson's dismal realism and what she calls the psychodynamic aspect to the lives of women who are leaving

prison. Their post-prison lives of women tended to be reactionary and full of anxiety, dealing with day-to-day chaos and just surviving. Serenity actually was in the first graduating cohort of CREW in 2007 and had taken it several times since during various bids. She liked CREW and thought that it “breaks you down to build you up” and was hard work (“you have like 40 pages of homework a night”). She had “learned a lot about myself taking CREW” but she never really went to Project Place after getting out of jail.

Mary’s Job Search After Prison

Mary was one woman who actually had getting a job in the forefront of her mind when she left prison. We met several months before she was released from MCI-Framingham. She was eager to get a job, she told me, and she had taken the "Re-entry" class offered at Framingham prior to her release. According to the Department of Corrections, the "Reentry and Employment Readiness Workshop" tries to prepare individuals for the reality of imminent release:

The 10-day Reentry and Employment Readiness Workshop meets for 2.5 hours per day and is offered to inmates who have a defined release date. During the Reentry and Employment Readiness Workshop, reentry planners facilitate curriculum designed to assist inmates in the development of the necessary skills that are needed for successful transition back into the community. The focus of the workshop is employment readiness to include resume building, cover letter, job application, mock interviews and how to maintain employment. The workshop also includes social support, housing plans, financial awareness and budgeting, educational referrals, criminal impact and attainable goal setting. Every inmate who attends the workshop will receive an Employment Readiness Release Portfolio. This release document can include identification, resume, cover letter, practice job applications, WOTC forms, Federal bonding, MassCor work verification, transcripts, certificates, and licenses. Once the inmate has completed the workshop the portfolio is stored within the institution and distributed on the day of release.

When I speak to Mary two days after she is released, she tells me that she was released with no plan and no formal address to be discharged to. Apparently, she had fallen through the cracks in the prison computer release system and no one had helped her with an individual discharge

plan. She tells me that they lined up one potential drug treatment program for her—a therapeutic community (TC) in East Boston called the Meridien House. She goes on to tell me this therapeutic community drug treatment house is particularly humiliating and she refused to go: "I'm not opposed to most therapeutic communities, but this one they make you wear signs and a dunce hat and stuff like that. Seriously, I would rather be on the street than go to this ridiculous program. Of course that was the one with availability."

Instead, she has gone back to her mother's in Somerville. She wants me to help her look for a job by typing up the resume that she hand-wrote in the employment readiness class at the prison. She laments that the re-entry class was far too short: "You need more than just one week [of the program] before you leave."

She was hoping to find work in the caring field as a home health aide or a nursing assistant. She tells me about her previous work and educational history: she had dropped out of high school (but soon thereafter obtained a GED) and had worked as a camp counselor, a nanny and at Dunkin' Donuts and Bruegger's Bagels. She also had started doing a nursing certificate but floundered with ongoing dabbles in drug use. She had always wanted to be a nurse because, according to her, "I think I'm empathic and good with people. Not everybody's fit for every job."

Mary had kept all the papers from her reentry class in a yellow folder with a quote from Martin Luther King Jr. pasted onto the front: "If you can't fly then run, if you can't run then walk, if you can't walk then crawl, but whatever you do you have to keep moving forward." She handed me a folder full of papers, including upcoming court dates for custody of her children, a soft-core pornographic letter that another inmate had written to a boyfriend and formal paperwork proving that she had been discharged from the prison.

One of the papers in her stuffed yellow folder was entitled “Interview Etiquette” spelled out the “soft skills” necessary for presenting oneself: arguably futile attempts at altering one’s habitus. “The way you look, speak, sit, stand, walk and just about every action reflect on your professionalism during a job interview. Other personal attributes so [sic] the same, including your attitude, body language, mannerisms and even how you smell are important aspects of having good job interview etiquette.” It spells out exactly what not to wear: tight or low cut clothes, objectionable hats or shirts. Don’t chew gum or smoke or eat. People are coached to “use the person’s name at least once in the conversation—Thank you Bill.”

The folder also contained examples of cover letters and resumes and information about Massachusetts “One-Stop Career Centers,” how to do a budget and how to get a credit report. In her pile of papers, she also was able to request a copy of her own CORI. She had also filled out a worksheet entitled “My Skills” (see below).

My Skills

The Three Skills I Possess: (Hint: get ideas by using your skills evidence worksheet)

Skill 1 Motivational Skills
Write three examples that demonstrate this skill:

Settle disagreements

Relate well to others

Persuade and guide

Sell ideas/promote

Skill 2 interpersonal Skills
Write three examples that demonstrate this skill:

Helpful

Empathetic

positive Attitude

Skill 3 Leadership Skills
Write three examples that demonstrate this skill:

manage self

identify problems and solutions

Accept responsibility

adapt to new situations

Figure 8.1: Page from Mary's skills workbook, re-entry class at MCI-Framingham

Mary had been incarcerated at least five times for charges ranging from possession of controlled substances (Neurontin, Class E substance for the most recent incarceration) to assaulting a police officer. I think about how the label "violent felon" includes her and how strange it is to meet a chunky, middle-aged white woman who fits this bill. It will largely prohibit her from joining the caring profession that she finds so appealing. She tries to practice writing out how she will deal with the question of her felonies.

Yes I've been convicted of a felony. I've had a difficult period in my life where I've made poor choices. I've learned from it and have worked to ~~make~~ change.

About myself
I am reliable, hardworking, ^{and} punctual, I am motivated and take pride in my work

Figure 8.2: Mary's handwritten response to being a felon

In the re-entry program, she also is tasked with anticipating what are called her main “speed bumps.” The first one is already filled out: “I have a record,” it reads.

Write down what you have identified as your three biggest speed bumps. The first one is filled out for you because you are going to need to address this at some point.

Speed Bump 1 I have a Record

Tools I have to overcome this.

I can look for Cori friendly jobs
I can use the incentives to help me.
After 10 years I can get my record sealed

Three things I can do starting today to address this identified speed bump

Stay out of trouble Use Re-entry to my best Use the incentives to help get job,
Coerce employer

Speed Bump 2 Staying Sober

Tools I have to overcome this.

Go to meetings, Hang around sober friends that have good recovery,

Three things I can do starting today to address this identified speed bump

make sobriety my #1 goal Sign up for I.O.P for when I
get on the streets with

Figure 8.3: “Speed Bump” worksheet from Mary's re-entry class

When I talked with Mary at her mother's apartment in elderly public housing in a small town north of Cambridge, she was excited to get a job. She had been released a week before, and actually made contact with me thinking I was a doctor. I got a text message from her two days after she was released from MCI-Framingham that mistakenly thought I was a prescribing physician: "Dr. Sui. Need help with something. My boyfriend n I had an accident n I need plan B. it costs \$50 so I would need a dr. to prescribe it, so I can pay for the prescription w/ my insurance card that way I would be able to acquire the medication. Don't know if u r able to assist. Let me know please."

I had encouraged her to go the Cambridge Hospital emergency room, where she obtained Plan B. She was squatting illegally in her mother's apartment. Mary had been released from prison and had nowhere to go, so they snuck Mary in by having her carry a bunch of boxes over her face in front of the apartment building security camera. She wasn't able to come and go freely as a result. Her mother was being evicted from her public housing because Mary stayed there several months earlier while on "the bracelet." No one who was not on the lease was technically allowed to stay in elderly public housing, and Mary wrote that was her address for her probation, so the apartment complex found out.

Mary was pursuing a number of potential jobs leads. She heard of a telemarketing group in Porter Square called Integral Resources that hired people with records. She also heard that the gym in Porter Square was "looking for employees desperately." She even reached out to Integral Resources. I thought she had scheduled an interview, but she never had. She told me she had a new outfit from T.J. Maxx so she would be "dressed appropriately." I met up with her boyfriend, who was homeless living in Harvard Square, and gave him the typed up resume and cover letters she had wanted. She had never worked in telemarketing, but had worked several jobs as a

nursing assistant at facilities that no longer existed. The people she listed as her supervisors could no longer be contacted. She wanted me to highlight skills she had done in her capacity as a nursing assistant: “Answering phones, people skills, reliability, dependability... Plus positive attitude that is contagious n makes for a pleasant work place.”

I knew that she could run a business. She had sold drugs for three years in a low-level operation near Cambridge using her contacts and her boyfriend's up-front money. She was able to answer phones, reliably supply drugs, and use her people skills to get customers. This was all consistent with her positive attitude and upbeat work ethic. She also had escorted for an upscale transportation-related company in Boston, with a different boyfriend who had initially supplied the money for their personal drug use. After a while, "He was a deadbeat and I had to always get the money [by escorting]."

When I talked to her several weeks later about how her job search was going, she told me she never went to any of the potential places of employment. She had instead been getting “wrecked” (high). She did not make it the doctors’ appointments she had made and was now sleeping on the street since her mother had been evicted. She was using heroin and also suboxone “trying to break the habit.” She was convinced she was pregnant and wanted a “maintenance” medication and an inpatient program; she had also missed a court date for her son’s DCF status/custody.

Mary was the most job-oriented of all the women I met who were leaving prison. I admired her for her sheer sense of go-gettedness, but she was ultimately ill equipped to carry out the job search. Getting a job was just only one of many anxieties that burdened Mary, that flitted across her mind, that made her feel guilty and contributed to an overall sense of failure. She also was thinking: Am I pregnant? How do I stay sober? How do I not be homeless? How do I get to

the doctor's office? Why did I miss my court date for my son? Do I have a warrant because I didn't report to probation?

I tried in vain to set her up with an appointment with the director of the Shattuck suboxone clinic—not necessarily to get on suboxone maintenance per se, but just to have someone to talk to who understood her situation and was willing to brainstorm ideas for getting out of it with her. Numerous times I encouraged her to go in even though she didn't have an appointment. She sent me a text message after one futile attempt: “Kim, I didn't go the appointment. Sorry it took me so long to get back u I guess as u probably know a person who is an addict can get caught up. I really dont want to be this way anymore. Prison for me is the wanted or unwanted boundaries placed in your head not necessarily where your feet are. So addiction is much like a prison of its own. Living in unacceptable conditions or what should be.”

What struck me about Mary was the way in which she wholeheartedly embraced the logic of recovery, the importance of a job to that recovery, but her social situation was dominated by her relative inability to make decisions that could extricate her from the morass of her unhappy life. Was she a co-creator of her own self-destruction, refusing to get better?

Work was no means to salvation for Mary. In fact, she was systematically excluded from participating in it. Her job search was rather a reminder of her existential failures and the low social value that women like her held in our social compact. Working is poorly regarded by this group as a space for generating positive emotions, experiences and meanings; drug use, on the other hand, holds the promise of providing meaningful, positive emotional and embodied experiences. As Mary told me, after doing several methadone pills that Scott had acquired for on the street just days after her release, "Drugs are very seductive, once you dance with it, once you have it, it feels too good to just stop—not caring that it's not good for you."

Profiting Off the Inevitability of Non-Recovery

Mary was not exceptional in her joblessness among women with histories of incarceration. There were some women I met for whom jobs just seemed like a distant dream. They seemed too sick, too tenaciously clinging to life itself, to think about getting a job. The material stability and the psychological equanimity that many take for granted before being able to embark on a job search seem sorely lacking. Such was the case with Serenity, a white woman who arguably was more productive to new economies of rehabilitation and “treatment” in her lack of recovery than in any future employment she could ever have.

As a sick woman who cycles in and out of increasingly for-profit, privatized drug treatment schemes, prisons and spaces of healthcare, she is arguably more useful to neoliberal regimes that profit from the inevitability of relapse, the fact that they will “keep coming back” (to turn a phrase as they say in AA). She and women like her cycle through overlapping and fragmentary nodes of care and punishment in ways that generate profit, create value for others, and create increasingly downtrodden subjectivities. Women, even more so than men, are punished for their deviance and perceived idleness/non-work, their inability to conform to middle-class, hetero-normative and white notions of the good woman, the good wife, the good mother (Campbell 2000; Campbell and Ettorre 2011; Roberts 1992; Allen, Flaherty, and Ely 2010).

Serenity gets conflicting information from her doctors and program administrators. Maybe she should just focus on taking care of her HIV since she has become resistant to many of the drug regimens over the years of her so-called “non-adherence”: “That’s what they say to me. Take care of yourself. That’s your job [now].” I tell her story at some length here to illustrate

what “recovery” from heroin addiction looks like. I hope to highlight why the goal of formal employment upon release from jail might be so far from her mind.

After Serenity and I first talk in the suboxone clinic, I realize that we had actually had met three years earlier in the Boston jail. At the time, I had been going in with a social worker from the Shattuck Hospital to set people up with primary care, mental health care and addiction services if they were uninsured. I remember seeing her sparkling green-gray eyes that flashed with intelligence and charm.

In the three years since we had last spoken, Serenity's life had gone much the same as the previous seven: that is, marked by an abject and cyclical movement between prisons and jails, hospitals, shelters and the streets. Serenity, in accordance with our society's attitudes towards self-care and the fervent belief that one can make decisions to leave this “lifestyle,” was plagued by guilt and misery; at one point I asked her what was her biggest health problem, and she asked me, “Are grief and guilt a health problem?”

As Serenity and I talk more, I keep unearthing layer upon layer of tragedies, accidents, traumas and bad luck. What sustains her now in her three-month inpatient drug treatment program? Why is now different than the many times she has attempted treatment before? Serenity is staying at a treatment program that she had “failed” before. When she was in the program several years ago, they went out one Sunday to go shopping for sundries and groceries. Serenity was caught shoplifting from the store and the police ran warrant checks on everyone on the field trip. Apparently half the program got arrested as a result—having outstanding warrants—so the program director wasn't too keen on letting Serenity back into the program this time. After all, their absence disrupts the ability for the treatment programs to bill insurance for

services.

Serenity has been incarcerated ten times in the past ten years—for larceny, possession and prostitution—all non-violent crimes that can be seen as crimes of survival in poverty, crimes forced upon the dispossessed by the rest of society. Serenity lived under a bridge for the last ten years; cast out in a semi-voluntary manner, she had left another state where she was born, in order to be closer to a steadier and cheaper supply of drugs. She prefers the routine, precarious danger of a life on the streets than the rules and confines of a shelter system, a sober house or a drug treatment program. Like Catarina in Joao Biehl's *Vita*, Serenity's body itself is exemplary of the way in which social machinery works to produce exclusion and marginality; as Biehl argues, "In their alleged incapacity to produce nothing else but bodily infections, parasites, and silent suffering lies the new role of these abandoned men and women as negative citizens" (Biehl 2001: 145). And she knows all too well that her failures produce profit for many others, influencing "her treatment."

Drug Treatment

The program that Serenity is in prepares her to "graduate" after three months. This is the longest time in her 13-year drug-using career that she has ever stayed at a program. While she was at the program, we planned to take her to the court to deal with her outstanding warrants. She has two in different jurisdictions. One is for selling drugs in a school zone; the other is for "common nightwalking." Recently, at a meeting of advocates to reform the drug laws, someone quipped, "All of Boston is a school zone." Serenity didn't even know that she was in a school zone, since the signs are not always posted. A recent albeit minor win for criminal justice reform occurred in Massachusetts when they decreased the size of the school zone from 300 feet to 150

feet.

Serenity is pretty sure the charge will be dismissed, but she still has an outstanding bench warrant to show up in court. There are generally two responses to having outstanding warrants: run or face the music. The majority of people run, hoping they won't get caught. They often manage to run for quite a while; their risk for getting picked up by the police depends on where they go and stay, if they are homeless, if they continue to engage in behaviors like shoplifting to support their drug habits, or if they hang around with guys who are doing delinquent things, dumb things like drinking in public. It's critical to pick the right time to face the music: if you're in treatment, have evidence of clean urines, or in other words, act like you're trying or that you give a shit, they usually are more lenient on you. It all depends on the judge, of course.

We are banking that since Serenity is in a three-month residential treatment program, that they will be lenient on her. But all of us, most of all Serenity, have to admit the possibility exists that she might have to go to jail. I am planning on taking her to court. We hope to bring a letter from the director of the outpatient addiction clinic as well as a letter from the director of her treatment program, along with her clean urines. We pick a day. I call Serenity at the treatment program's phone number; she picks up and says that we can't go that day, since she doesn't have approval to leave the program and she also doesn't have a letter from the director yet. So we wait.

In the meantime, Serenity "graduates" the program. This is the first time she has ever graduated anything. She technically graduated when they found her a bed at another residential treatment program, even though she had failed before at the other program. When they find you another bed, you should just be lucky that you're not getting discharged back to the streets. Even if it's a program you've failed at before, maybe this time the treatment will stick.

Serenity doesn't last more than six hours at her new program. Her boyfriend from the old program comes to find her and they pick up again. Same old thing, same old people, same old corners. She has to head to the place where she knows everyone—where she's sold crack on the corner. She thinks often of her children; she sends messages to them on Facebook whenever she can get to a computer.

Serenity calls the suboxone clinic after a month of no contact. She reports that she is in a detox facility down near BMC. We make plans to bring her to the clinic, try to start getting things in order for her. Physical detox is the easy part. Most detox facilities don't have the staff or the resources to help people find somewhere to go after they detox. There are fewer and fewer long-term drug treatment beds, even relatively short 30-day ones. And what is the financial incentive for detox facilities to actually help cure you of addiction in the long-term when they can bill MassHealth (Medicaid) twelve times a year for your "visits" if you fail to get better?

They usually give you a list of phone numbers and expect you do the heavy lifting; after all, that's a vital part of treatment, taking some responsibility for your addiction and participating in your treatment plan. What that means, though, is getting yourself on a lot of wait lists, learning what time to call programs (in the afternoons, when other people have left and groups are less likely to be going on). Currently, there are 3200 people on waiting lists for residential treatment programs. The onus falls on the individual to call every single day and jump through each program's specific requirements for entry.

We make a plan with Serenity while she is at detox that I will pick her up on the morning of her last day, say 10am. When I arrive at the detox, I have to ask which door is for the detox and which door is for the shelter. I travel around a length of fence and enter an unmarked door near a dumpster. I am buzzed in through the door. The lady at the front desk looks up with

disinterest. When I say that I am Serenity's ride, she just looks at me. "I can neither confirm or deny that she is here or that she left," she says, saying with her eyes and eyebrows and a tone of her voice that all tell me that Serenity was there and checked herself out already.

Months later, when she shows back up at the clinic, Serenity tells me she left at 8am, knowing that I was coming at 10am. "I had big plans," she said simply. It wasn't anything personal. Many people use the detoxes as a way to moderate or diminish their tolerance. They are safe havens when you run out of money or drugs and also the energy and wherewithal to acquire money or drugs.

What no one tells you is the detox loads you up with clonidine, suboxone or methadone for two to three days, then sets you free. Many people use go right back out intending to use again. For those who don't necessarily plan on that course of action, you have to then figure out how and where you're going to "detox from the detox." Even for women and men that do find a place to go in a Transitional Stabilization Services (TSS) or a Clinical Stabilization Services program (CSS), the urge to leave to use is strong because you still feel bad.

We are all relieved that she is okay when she shows up. Everyone at the clinic likes her. I think this is because she is friendly and also has great insight into her addiction. In the intervening time, six weeks of being missing in action, she has been completely off the grid. Her phone number ran out and became disconnected. Her medications, including her HIV medication, had been stolen in a shelter. That's just a well-known peril of shelter life; medications may be the most valuable possessions you own.

Sometimes she shows up to the clinic on a Friday afternoon. She fills her prescription – for \$3.50 co-pay, or even getting the co-pay waived at certain pharmacies where they know you—for a week's worth of suboxone tablets (two a day, on average, so approximately fourteen

or fifteen). She can sell them on the street for \$10 a pill; \$150 can get a lot of heroin.

She even takes some of the suboxones intermittently and also use heroin, although she claims sometimes that she's often "dumb" about it, using heroin too soon after she has used the suboxone and can't feel anything. She beats herself up about it: "It's pointless, I know because I'm taking suboxone. I'm good, and then somebody's in my face, loading a needle, "Oh, you want half of this?" Yeah, okay, you can't feel a fucking thing. All you're doing is giving yourself a dirty urine so when you get picked up you really fuck yourself, how smart can you be?"

Serenity signs herself up for a program that's a 6-month residential treatment facility in Quincy. To get in, you need fourteen days of clean time. Serenity can't even get to those fourteen days. She attributes her inability to stop using primarily to the homelessness: "That's our biggest problem now, being homeless, being around drugs. It's so in your face."

She knows that the last time she used was around 48 hours ago, but she calculates that it takes longer for her body to clear because of the Hepatitis C. So she expects it will be longer for her than the average 72 hours. We try to plan to find a date when she can turn herself in to see the judge. She concocts a story for the judge about why it's taken her so long to turn herself in. And she knows that she has got to produce a clean urine for the probation officer. A clean urine is necessary, but not sufficient, for avoiding jail.

One thing that keeps Serenity going is the memory of her children and the potential, albeit slim, to be back in their lives at some time in the future. Like most other women who use drugs, Serenity prizes and values her relationship with her children and her memories of mothering them. She hasn't seen her children in ten years, but she is so proud of them, especially the oldest one, Megan, who has turned out to be a strong woman and mother of her own. "When I look at her, I know I didn't make junk," Serenity beams, thinking about her oldest daughter.

Serenity accredits part of Megan's strength and morality partly to the way that she raised Megan. When Megan tells Serenity, "Mom, I love you, but you're making bad choices and I can't have you in my life," Serenity takes it as a sign that she did right by this daughter in some way. "I hand a hand in that," she explains.

Megan and Serenity had a loving yet tortured relationship. At fifteen years old, Megan confronted Serenity in their small apartment, insisting that if her mother didn't shoot her up, she was going to go find someone else to do it. In despair, Serenity agreed. It was part of being a good mother, to do it safely, to clean the area with rubbing alcohol, to make sure that you were in a vein. She was afraid that her daughter "wouldn't know you could always put more in." If someone else did it, she might overdose, or "give her too much and take advantage of her." Megan and Serenity used together for a year. Like mother, like daughter. Serenity figures that "children learn what they live."

One day, they were in western Massachusetts and they were arrested with a bag of heroin. Megan would never return, scared by the incident. Serenity and her boyfriend, driven by their addiction, took the other kids and moved to Springfield to be closer to their dealer. They were arrested again for shoplifting. Serenity's mother bailed her out, but when Serenity called her boyfriend's mother, she refused to bail him out. Later, Serenity learned that his mother had coerced him into signing over guardianship of the kids. Serenity was furious: "I couldn't stand to look at him. I tried for a couple of months but I couldn't even look at him. I hated him I felt like he gave my life away." They continued to use, even more heavily than ever now that the children were gone.

It's common for addicts to say they were trying to "stuff my emotions." Serenity and her boyfriend had a \$500/day habit between the two of them. Disgusted by the sight of the father of

her children, who had signed away her life, Serenity engaged in a series of self-destructive thoughts and behaviors, including trying to overdose on heroin many times. She also knowingly had unprotected sex with someone who was HIV-positive, hoping she would die. She likes to say, “Joke’s on me! Guess it don’t work that way.”

Jail (Again) & Court

The next time I see Serenity again she has been incarcerated for forty days. Word on the street was that she was locked up. It turns out that she was, that she had been arrested on the previous bench warrant (for a hand-to-hand in a school zone) that we had tried to have cleared up. She imagines that someone called the cops when she was walking through a park in Chinatown near South Station. She had just emerged from an alley, where people go to sleep and get high, when she was picked up by a “couple of young rookies.” When they checked her ID, they found her warrant.

So it was back again to “the only detox I really know”—jail. She received some librium (a benzodiazepine used for a medical detoxification from alcohol) while she detoxed in jail “only because I told them I drank” in order to feel a little bit less uncomfortable. She told me she secretly wished to get locked up to just get ahold of her heroin habit: “Every time I sit on the church steps getting high, praying to God, just send me to jail... and the thing is, I can’t go see [my social worker] but two weeks later, I always end up in jail.”

She was happy to see me when she saw who had called her out of her cell, but she’s always happy to see me when she’s sober and she always avoids me when she’s not. I was allowed to see her in a private classroom on the programming floor. Ten minutes later, we were kicked out of that classroom for meditation class to come in. Serenity was getting ready for her

court date. She expected that she would not get a chance at bail because she had too many “defaults” —that is, she would be released from jail contingent upon her promise to show up for her court date, but she never would. Then it was a matter of just catching her when they could. Serenity hoped to bring this case to trial. She felt indignant about the notion of pleading out to something that they didn’t have evidence for: “I won’t plea out to the distribution in a school zone, it’s beatable.” She is worried though about her public defender, whom she calls a “public pretender.”

She is otherwise feeling well, noting “I haven’t missed any of my medication in the 40 days that I’ve been here.” She is glad that she is not on the street, as her boyfriend Oscar had tried to kill her, vowing to her, that he didn’t care if he went back to prison. Here inside is comfortable. The staff, the case workers, the guards, they all know her. They roll her eyes when she comes in, but it’s comfortable for her.

She hopes that at her court date in a couple days that “I come back here until I go to trial.” The reason: “I don’t use when I’m here.” She could very well access illicit drugs, but she doesn’t. She feels safe and calm in jail and receives her HIV medications regularly. There is a rhythm to being in jail that she lacks when she’s out on the street: “Breakfast between 7 and 7:20, locked back up quarter of eight. Come out, take a shower. Locked back in at 11. 12:20 come out, eat, locked back up til 1. Out til 2:30. Then we lock in for another hour, come out at 3:30. Eat at 4:30. Locked up til 7:30. Locked up at 9:30.”

Serenity is concerned that when she will be released into the streets of Boston. She tells me: “I was just talking to my Unit Officer. I did the three months [in a drug treatment program]. I graduate. I get out, to what? To go nowhere. And three months is not going to fix me. Six months is not going to fix me. It’s not! And that’s the reality of my world. I want to go

somewhere that's for like a year, eighteen months. That's what I want."

I next see Serenity at the Boston Municipal Court. The charges she is facing are old: they are from 2011. There are several of them: Trespass (from fall 2011); Streetwalker, common (winter 2011); Municipal by-law or ordinance viol (winter 2012) and there is a motion on the last two: Drug distribute class B (winter 2012) and drug violation near school/park (winter 2012). All the cases on this judge's docket are listed on a piece of paper outside the courtroom.

Her name is called, and I look around the courtroom. She is apparently still downstairs in the sheriff county holding area. I learn this is common: for people to not be brought up in time for their cases. When Serenity's case gets called again, she has been brought up by the guards.

Serenity's harried, young public defender comes to stand up opposite the Commonwealth lawyer. They use antiquated terms, oddly calling each other "my brother" and "my sister." The judge is mad. She turns to the Commonwealth: "This case is a year and a half old," referring to the January 2012 charge of selling in a school zone. "Have you received the discovery?" The prosecutor for the Commonwealth pleads for more time to get the discovery (the lab evidence), "We understand the final discovery was requested, but we understand this was a Hinton lab case."

The judge interrupted, "That doesn't matter. It's a year and a half later. Where's the discovery?" The DA pleads for more time, "Your Honor, we're asking for another day to provide the discovery." "You're not getting it," the judge says. "After a year and a half, they still don't have any bench drugs. You still don't have discovery?" The judge asks about the distance from the school; the DA pleads that they think they have measurements attesting to the school zone distance. The judge comes back to the drugs. "February 2012? But you don't have the lab results?"

Why? Somebody's not doing their job here."

Serenity's lawyer makes a motion to dismiss the case, given the lack of evidence. The judge says she will consider it and they agree to meet again in a month. It looks highly likely that Serenity will be released the next time she goes to court.

Freedom

Serenity is torn between the facts of her life and her affective states that swing between her alternating yearnings to use drugs and to be sober. For her, being sober is not necessarily synonymous with being well or with being happy. Getting on the path to sobriety is not easy or immediate and the benefits are not immediately perceived. She oscillates between conflicting desires: to use drugs, to continue her chronically dangerous and insecure street life, but one well trampled and familiar, or to embark on therapeutic quests seeking sobriety, a route she has attempted several times before and has failed to navigate into a sober existence. She is rightly discouraged by her previous experiences with the drug treatment system that seems to neither care if she succeeds or fails.

Addicts call the act of searching for sobriety "getting well." Unfortunately, many of them are used to only "getting well" when they are involuntarily confined in prisons or jails. Even when they go to detoxes in hospitals or in the community, they can voluntarily leave any time, tramp off to go get high. This happens often, despite the best of intentions.

"Getting well" takes a long time. It might takes months for people to feel comfortable in their own bodies as the deposits of drugs are washed from organs, tissues and brain cells. The physical discomfort is at its peak in the first week but irritability, psychological discomfort and sleep issues can continue for months. Ironically, for Serenity, this has only ever happened in jail,

because there is no time in the past ten years that she has been able to stay sober longer than three or four months. Serenity hates herself for being “institutionalized.” By that she means that she only ever achieves this period of physical and psychological even-keel when she is incarcerated.

Yet she also badly wants to be free. She dissed her lawyer's previous actions because she did not make enough effort to get her free, not asking for bail reduction, not asking for dismissals. She also knows that when she is released, she will get right back to using drugs where she left off. She will not take her HIV medication, she will not go to her doctors' appointments, she will not be in any better place to talk to or ever see her children, and she will continue to be homeless and selling drugs in order to feed her heroin habit.

Hospitalization: “You’re like a prisoner in the hospital”

August 1. The suboxone clinic has a phone call from a social worker at one of the major hospitals that they have Serenity in their hospital for cellulitis of her face. Serenity had checked in the day before with an abscess on her face next to her right ear and her whole eye had swollen shut with inflammation. Steve, her best friend, told me he thought it looked like she had gotten beat up.

Serenity was at the hospital for only one night. She left Against Medical Advice (AMA) because she was transferred to a room where she could have no visitors. She insisted that Steve be able to come in. Steve tried to talk her down, saying they would talk on the phone. She was enraged by the staff treating her “like a prisoner in the hospital.” She felt like because she was a drug addict, they were more rigid about the rules. They “won’t let me wear my own clothes, they’re up my ass about who visits you... I was a person before I was a patient. Yes, I’m sick, I

need medical attention, but you're not going to dictate who I can and can't see." It all has to do with the stigmata of addiction: "Once they find out you're a junkie, you're a prisoner there, and I won't go there." The hospital sent her a prescription for antibiotics and Steve doled them out to her. He told me he had also held onto her suboxones for her so that she wouldn't sell them: "I'm not interested in them, I don't like that stuff. I keep them with me and give them to her every day."

Two months go by. October 11. Serenity is still out and about getting high, even though she had insisted in jail that she was "sick and tired of being sick and tired" (an AA line). I get a phone call that she is inpatient at another hospital getting IV antibiotics. She had ended up with a cellulitis after a jugular vein shot gone awry. She asked someone to shoot up a speedball into her neck. She usually does it herself with a mirror, but when she has a cold, she can't hold her breath long enough so she starts to pass out. She thinks the coke numbed the area and the guy just pushed it up anyways, eager to get his share. The needle was dull because it had been used far too many times. It was like pushing a fat sewing needle up into her neck.

She tells me that she should have come to the hospital two weeks earlier. She kept rationalizing why she shouldn't go in. I can't go to the hospital dopesick. Oh, I can't go to the hospital because it's the weekend, and they don't have an emergency room. Oh, it doesn't look so bad today. All the street addicts were yelling at her to go to the hospital: "That's an infection above your heart, go the hospital." Finally, the pain was unbearable.

Serenity feels old. "I don't bounce back after my runs," she concedes. She also feels like her runs of drug use are shorter. She has mixed feelings about God, but she always refers to a sense that he is manipulating her like a chess piece. "God does for me what I can't do for myself. He got me sick, he let me be stupid so I'd get sick."

Her life on the streets is full of chronic despair: “I just don’t have it in me anymore, I am tired. I see people walking around, they’re clean, they smell clean, they have a smile on their faces, they have a destination to go to, they have a life. I don’t have to sleep in Port-a-Potties under the bridge, and I don’t want to anymore.” She yearns for a place to go, for a life that she once thought she could have: being a mother, having a white-picket fence, being a nurse. Those all seem so distant.

I ask her if she thinks that her life would have been different if the jail had “treated” her differently, if she had not been released straight from court back to the streets. She tells me that she feels like the jail has just given up on her and she insists it is not right to give up on anyone. She is critical of a system that exists to feed off her failures and relapses: “Because you’re job security for them. That’s money in their pocket. They really don’t give two shits, especially for someone like me that’s a frequent flyer. They just give up. Oh well. She’s coming back, she’s not going to go [to a program]... I’m a lost cause... I see it differently. I don’t care if you fail a million times, maybe on the million and one times you’re going to get it.” She thinks they throw up their hands because “the prison industries keep making more and more money off of people like me, because that’s what we do.”

Even as she simultaneously recognizes the profit motive involved in her chronic and cyclical incarcerations, she also has internalized the sense that she is ultimately the one responsible for her own sobriety. She keeps failing. The buck stops with her, it is her fault she is still addicted. This is in accordance with a cultural shift in American values about one’s body and personal responsibility towards the collective for one’s health. As historian Allan Brandt has written, “[John] Knowles [president of the Rockefeller Foundation] called for a return to Puritan values of self-discipline and moral restraint. Eager to reduce the “dole” implicit in rising health

expenditures, Knowles suggested that “the idea of a right” to health should be replaced by the idea of an individual moral obligation to preserve one’s own health... a public duty if you will” (Knowles 1977)” (Brandt 1997:64).

Serenity makes it clear that there are many moments of potential intervention: “It’s not only the hospitals and jails but the judges.” She has ideas about how the judges and the court systems can better intervene instead of just getting her quickly off their docket:

If you look at somebody’s record and you see they’re there for prostitution and they have two misdemeanors: I’m chronically homeless, that’s why I get trespassing. Prostitution, why don’t we send her back there [to jail] until you find a program and your probation starts as of today, but you need to stay in South Bay detained until you can go to a program and you’re stipulated to do a program. I think sometimes the system and the jails fail people. And sometimes you’re going to hit the road anyways but why not give it a shot?

We play out a scenario. I ask her if the judge squared with her and directly asked about if her “crimes” were related to addiction, she tells me she would have squared back with the judge: Yes. “If the judge would have asked me, if I release you on probation, are you going to have somewhere to go and use?” I would have said, “Probably, 99% [likely], chances are I’m going to use if you release me today.”

So the cycle between hospitals and jails and homeless shelters that constitutes Serenity’s life continues. And she cannot imagine a life in which her drug addiction is unlinked from the criminal justice. She has not succeeded in community drug treatment programs yet she holds out hope that one day she will be able to stop. Getting a job is not even on her mind.

Weak Weapons, Neoliberalism and New Economies of Recovery and Rehabilitation

Women like Serenity and Mary lack the social, educational or cultural capital to leave lives largely defined by poverty and poor health. Their relationships, their abilities to take care of themselves and others and the many kinds of contributions they bring forth just being in the

world are sorely undervalued and underweighted in a society where having money, privilege or even the ability to live a life of modest material comforts is hard fought and even more increasingly hard won. They have “weak weapons,” to use James Scott’s (1987) term, and their forms of resistance to treatment and carceral regimes are often turned inwards at themselves. As Pierre Bourdieu turned the phrase, “The weapons of the weak are weak weapons” (Lovell 2004: 52). These women resist hegemonic systems of medicine and carceral treatment in their anxious replies, their stubborn tears, their failure to show up to appointments for doctors or probation officers. They sometimes turn the sword back on themselves in protest.

Women like Serenity move through worlds in which for-profit and profitable non-profit institutions dominate and shape the course of their lives. The bodies of addicted women are not just forms of profit for these industries; they are also the straw-women of the War on Drugs that absorb a collective hostility and resentment, fulfilling carnal desires to punish those seen as dangerous or deviant. Women are punished and criminalized for their sickness, their inability to not get well.

Such notions of recovery and relapse in drug addiction as chronic and multiple open up women’s lives for infinite points of state, for-profit and nongovernmental surveillance, regulation and intervention. There are many forces and companies of varying quality invested in such providing such “help.” While prisons are not yet privatized in Massachusetts, the prison healthcare has been contracted out to national for-profit prison healthcare industries. Even the drug treatment in MCI-Framingham is run by an organization called Spectrum Drug Treatment that has expanded from community programs into the prison. Community drug treatment programs are increasingly for-profit ventures as addiction and mental health gain parity in legislation with medical conditions.

The increasingly prominent role of private industry in providing for the healthcare of women with addiction is part of an overall economic philosophy and mode of governance known as “neoliberalism.” Originally a repudiation of Keynesian welfare state economics, proponents of neoliberalism argued that the government distorted the market and that *laissez faire* economics and free trade would provide a greater benefit to society. Neoliberal ideologies also espoused the roles and responsibilities of individuals for securing their own welfare and well-being: the creation of “active” and “responsible” citizens (Ferguson 2010: 172). I use neoliberalism primarily here as David Harvey (2007) has argued (see also Morgen and Maskovsky 2003 for a relevant of neoliberalism and welfare reform efforts)—that is, as being a certain kind of “class project”—or “a set of highly interested public policies that have vastly enriched the holders of capital, while leading to increasing inequality, insecurity, loss of public services, and a general deterioration of quality of life for the poor and working classes” (Ferguson 2009: 170).

How exactly, then, do neoliberal ideologies and for-profit ventures configure into the “politics of life itself” (Rose 2006)? More specifically, what does it mean when businesses are profiting off of the “sickness” and the “non-recovery” of the poor? In Massachusetts in 2007, there were over 106,000 admissions to drug treatment programs according to the Massachusetts Department of Public Health; alcohol and heroin were the drugs of choice in respectively 41% and 36% of admissions. There was also a total of 44,106 admissions to short-term programs (less than 30 days, including “Post-Detox/Pre Recovery” and 42,255 outpatient drug treatment admissions (Bureau of Substance Abuse Services 2007). Plainly speaking, there is no incentive for cure by those tasked with the curing when people constantly revolve through an ever-churning drug treatment. Are sick and/or “deviant” bodies “useful” not because they can labor

for the common good of all but because working on their damaged conditions can create labor and profit for a select few?

What Works?

Not all of the women I met experienced the devaluation and disempowerment of alienation from the labor market and from being incarcerated. Mae, the 22-year-old whose mother would sneak her drugs into the prison, returned from prison to her wealthy white community. She did not look for a job and she did not try to go back to school—there was no economic imperative. She had no idea what she wanted to do or be and was comfortable sleeping in the twin bed of her childhood home. While her parents pressured her to get Food Stamps to help the family out, she was not prodded to get a job.

When I met up with her at Panera Bread for lunch, she told me, "I'm really lazy about filling out paperwork, you know what I mean? I wish I didn't have to fill out job applications. I wish I could just go in." She was replete in heroin: her mom would buy the bag, and she wouldn't get in trouble, because her mom needed her to shoot her up, so it "worked out." They would shoot up together in the parking lot of the hospital, because the last time she had gotten out of jail, she overdosed three times in one week. Harm reduction to be close to the hospital, they reasoned.

Mae was much better off than many of the other poor heroin users I met. She had a steady supply of drugs, a stable place to live and had the general support of her family. She wanted money for sundries and cigarettes, but overall her days were leisurely. She did not have to resort to working and felt no imperative to be "useful" or "productive." While she saw her heroin use as potentially problematic in the future, it was a manageable habit. She perceived herself as safe from the police since she only had one dealer.

Mae had been incarcerated in the prison's state pre-release facility for women. She did not work while she was there, nor was that uncommon. Even though the pre-release was unlocked, and women were encouraged to get jobs and would be transported by the pre-release facility to and from these jobs, of the several hundred women there, only a handful were working. There was a widespread refutation that working was valuable, that labor was a means to salvation as Weber had suggested was a key aspect of modernity.

Being locked out of the formal labor market did not mean that women were disinterested in working or the forms of meaning and potential benefits that working could confer. Brittany had discovered dignity, albeit in the underworld, by seizing control of her town's Percocet market and becoming its top supplier and pill dealer. In her work as a drug dealer, she had the freedom to organize her own activities, to charge her own prices, to make her own "plays." She had reliable customers; conversely, she had people relying on her. It was empowering to be a female drug dealer in a world often dominated by men.

After she was released from prison, Brittany's father eventually managed to get her a job in the shipping and packing division of the company where he had worked for the past thirty years. It was important for her to "just get a job and have a safe place to live, those are the two main things that I need to be focusing on." She was worried, though, because shipping and packing seemed boring and tedious, and the money she would earn would be a trigger for her. Any amount over \$100 would be a trigger for buying dope, and in her enterprising mind, she would immediately try to flip it--to get her drugs "for free." You can at least double your money. She was worried she would be bored and relatively rich—a bad combination for her.

Boredom is the foresworn enemy of recovering heroin addicts. One of the greatest risks of relapse to heroin is boredom, as all addicts are told repeatedly in drug treatment programs.

They are often asked, “What are you going to do to keep yourself busy?” It is a serious question—this question of busyness.

Drug addicts—when they are actively feeding a habit—are some of the most industrious people around (Bourgois and Schonberg 2009; Romero-Daza, Weeks, and Singer 2010). They work hard, because if they don’t work hard, they will suffer physical consequences like withdrawal. The constantly looming threat of withdrawal forces people into activity. Recovery or sobriety, on the other hand, can be plagued by boredom. Narcotics Anonymous warns that addicts in recovery have to be vigilant against boredom. In the *Basic Text*, it reads:

Sometimes it seems as though nothing changes. We get up and go to the same job every day... After the hell of our addiction and the roller-coaster craziness of early recovery, the stable life may have some appeal—for a while. But, eventually, we realize we want something more. Sooner or later, we become turned off to the creeping monotony and boredom in our lives. There are sure to be times when we feel vaguely dissatisfied with our recovery. We feel as though we’re missing something for some reason, but we don’t know what or why...?

There is a definite pejorative nature to boredom. As the saying goes, “Idle hands are the devil’s tools.” Boredom, according to a pervasive cultural logic, is mostly one’s own fault. It is one’s moral obligation to keep busy. Boredom means that one is not working, one is not a productive member of society.

Bruce O’Neill suggests in his work with the downwardly mobile, now homeless individuals in post-socialist Romania that boredom is structurally and economically determined. Rather than a bourgeois concept—idle because of the lack of economic necessity to labor—boredom is a process of coming “to terms with not being needed in an era of intensified production and consumption” (O’Neill 2011). Idleness—having nothing to do—is preconditioned by structures of power and the rules of the (economic) game. But it also alters women’s subjectivity, their sense of time, contributing to a thick feeling of swimming in fog that feels purposeless, necessary yet somehow fruitless. This wayward and errant sense of time

contributes to their desire to use, to wake up, to feel. Women in recovery try to cultivate meaningful relationships with each other and their children, generally disavowing work that has disavowed them. They have turned away from "submission to the rules of the established order" and the "relations of exploitation" that govern their lives and emotions (Althusser 1971:132).

Their denial of values of the values so cherished by capitalist ideologies is a maddening refutation of dominant middle-class morality. Poor people who refuse to be a redundant, cheap and expedient labor force are punished with new forms of banishment and racialized second-class citizenship (Alexander 2010). Poor women who seize control of their lives by becoming drug dealers mirror the cultural logic of capitalism, as Randall Contreras (2013) observes so keenly in his ethnographic memoir about Dominican drug robbers who violently rob other drug dealers and Philippe Bourgois (2001) notes in his early work with crack dealers. They are punished for being caught participating in attempts at making labor meaningful according to the dominant capitalist ethos, for trying to derive value and self-efficacy in one's work. And in the case of women who use heroin, ultimately, they are punished by the mark of a criminal record, denied entry into forms of work they find meaningful (the caring industry) and are blamed for their lack of work ethic, thrift, and self-discipline.¹²⁶

Work is no salvation for these women who are effectively locked out from participating in the formal labor economy. And little money is spent on education and other proven "evidence-based" solutions to getting women out of poverty and out of the prison system. In fact, in Massachusetts, there is a 3000-person waiting list for participation in the Boston Prison Education Project, a college prison education project, effectively shutting out people for years. Only 2% of money spent in state prisons is devoted to programming (including all of drug

¹²⁶ Hanson of Project Place noted that men who have been incarcerated can work unionized construction jobs often earning \$20 an hour or more. Women have no equivalently forgiving industry.

treatment, education, vocational training, etc—see the figure below, with the green slice of the pie chart representing programming expenses).¹²⁷

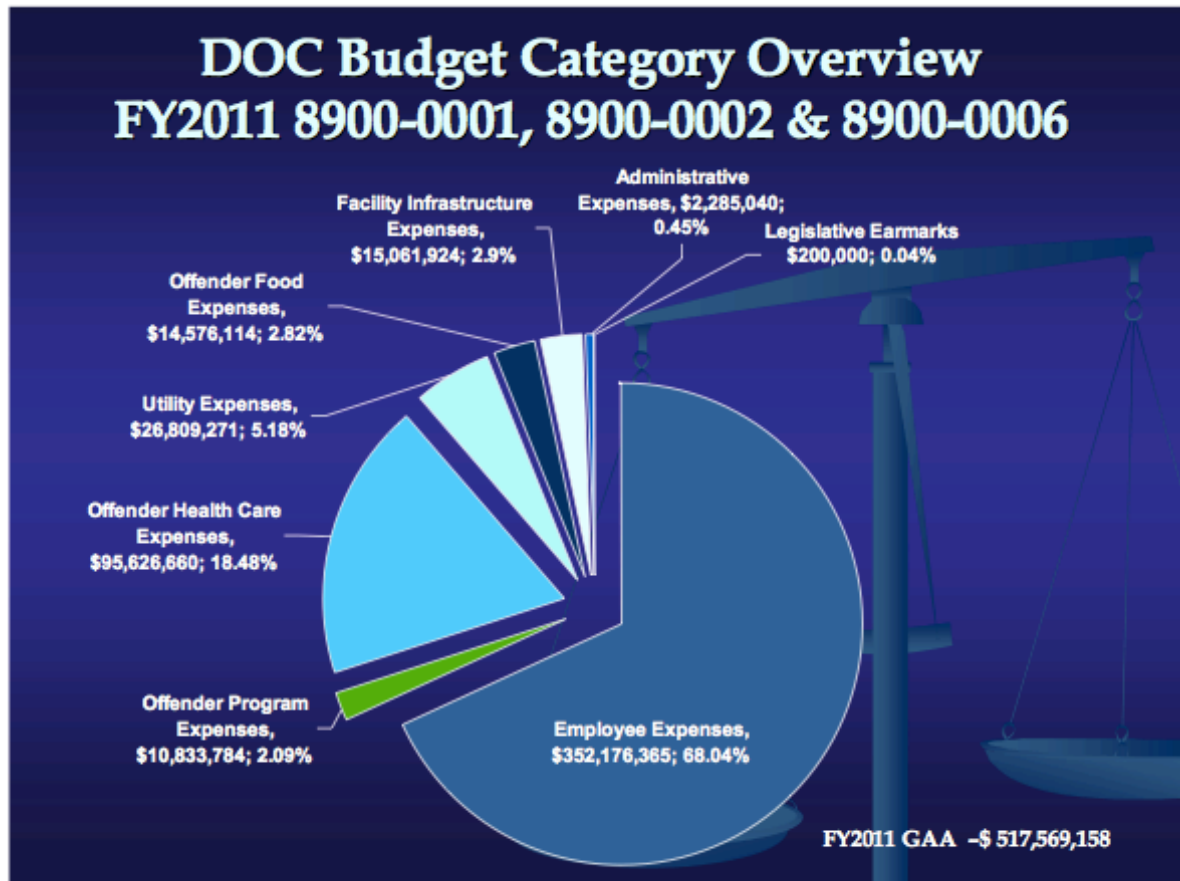


Figure 8.4: DOC budget, FY2011 (Massachusetts Department of Corrections Annual Report 2011, pg. 46)

¹²⁷ See Sweeney’s (2010) assessment of the role of education in prison programs. She reviews criminologist Austin MacCormick’s argument that “penal education should be yoked to the goal of ‘individual diagnosis, prescription and treatment’ for every prisoner” and foster “conformity with understanding” so that prisoners could “fit into the social scheme understandingly and willingly”; “in his view, penal education should inculcate ‘civic ideals’ and increase each prisoner’s ‘understanding of human beings, himself included, and of human motives, impulses, habits, tendencies and development.’ ... although such ‘cultural education’ has no relation to earning power, MacCormick argues, it plays a crucial role in making prisoners ‘better citizen[s]’ by introducing them to “new ways of living, new competence... in living itself in the complex social relationships of modern life... new richness, new outlooks, new horizons” (Sweeney 2010: 47).

The Department of Corrections figure shows starkly how expensive it is to pay for prison guards, their overtime, their healthcare. While I have devoted this time to examining the “programming” and treatment that many women in prison receive, it receive an ever-smaller sliver of the overall Corrections budget. In other states, like New York, they know that giving women access to higher education—to college degrees—keeps them out of prison. Women on the Rise Telling Her Story (WORTH), an advocacy organization led by formerly incarcerated women based out of New York City, stress that educational opportunities helped lift them out of their former lives of crime. They were able to find self-actualization and economic empowerment in concrete ways, rather than remaining mired in the jobs that the prison tended to prepare them for.

Yet Massachusetts is a punitive state even though it has a liberal reputation. Our state’s addiction to punishment—our habit of relying on prisons, in other words—is costly in dollars but also something deeper, in the erosion of our communally held values, our ethical orientations to taking care of each other. These are historically unjust social institutions that deny freedom, humanity, and a sense of belonging. They perpetuate and exacerbate sickness and poverty, catching people as the holes in the social safety net widen and pour out the poor and the mentally ill. The prisons and what happens within their walls perpetuate largely invisible, everyday violence—often cloaked under rhetoric of care and treatment—on poor individuals targeted for their unseemly consumption.

Conclusion: “Global Health” At Home and the Evolving War on Drugs

“One could always find reasons to blame the poverty-stricken and exploited—even in the course of calling for reform in their conditions of life.” -Charles Rosenberg (1997:40)

Near the end of when I was writing this dissertation, I was in Boston giving a talk. I was surprised because I made a phone call to Lydia to check up on her and she actually called me back. Her phone usually was dead and I would leave long-winded messages imploring her to call me back or text me. The last I had heard from her she had gone to detox at the psychiatric ward of one of the Boston hospitals, from there going to stay at the Boston Healthcare for the Homeless’ Barbara McGuinness House. Lydia was never that adept with her phone, although it did help her leap through technological time and space, skipping computers, in order to learn how to make her own videos and connect with others via Facebook.

When I picked up, she proceeded to tell me how good she was doing. She was doing so good, in fact, that her mother let her come back home to stay for a while during Christmas and the holidays. She asked me if she had any paperwork showing that she had been in the hospital because she had a court date that she had failed to meet because she overslept. I told her I had papers showing she was in the hospital many months ago—did she want those? She did, it turns out. I didn’t know how it was going to prove that she was unable to go to the court date she missed the day before, but if she felt better about having discharge papers from several months ago, I was happy to bring them to her. She anxiously asked me when I could be at her mother’s house in Everett.

We agreed on early the next morning, a Wednesday. I’ll go to Harvard, print the papers out, and then head to Everett. She was pleased with that plan. Later that night, I received a text

message from her with her mother's address. She also wrote a me lengthy note: "Kim, I wanna thank you so much for all that you've given me you've done wonders for me in the short time we've known each other & my heart is filled with so much thanks& appreciation you will never know how much &i love you for all you have done THANK YOU SO VERY MUCH HOPE YOU HAVE THE HAPPIEST OF HOLIDAYS SINCERELY LYDIA."

The next morning, after I duly printed out the paperwork that she wanted, I called her, ready to head over on two buses to Everett. She didn't pick up and she didn't answer my text messages. I had decided earlier—as a general rule, having gotten burned several times—to not go anywhere without confirmation of the plan a couple hours ahead of time. So I didn't go out to Everett. I thought it odd that Lydia had seemed so insistent on me coming early. Why had she been so anxious about getting the papers? Many thoughts rushed through my head, but I thought the most likely situation was that she overslept or that her phone had died. She tended to sleep really badly at nighttime and often slept late into the morning or even into the afternoon. I had mused before about the bad sleep habits of heroin addicts, so I wouldn't be surprised if she was still sleeping.

Several days later, I got a call from the clinic. Lydia had overdosed and died. Her mother found her on the bathroom floor the morning that I was supposed to head over there. Later on, after she and I had talked, she headed over to Chelsea, her old stomping ground, to see a friend. She must have scored some heroin and did too much. Her mother told me when we tried to make sense: "But she was doing so good! That's why I let her come home." Unfortunately, being clean and sober—losing physiological tolerance—made her susceptible to overdose. Had she wanted to die though? How could we know her thoughts in those last moments?

I thought seriously about what we—the clinic, the doctors that cared for her, me personally—could have done to prevent this. Maybe we should have prescribed her Narcan (naloxone) so that she or others could use it to reverse overdoses. Heroin overdoses are preventable if others recognize the signs of overdose and can administer the life-saving medicine in time. Maybe we should have encouraged her not to use alone, to use with friends, in relative safety. Maybe we should have had someone from the clinic visit her at her mother's house, just to check up on her, make sure that she was doing okay.

All of these questions center around one main presumption, which is that we think—we hope—that the clinic can be a site for ameliorating the wounds of social injustice. The glaring limitations of the clinic, its paltry access into the lives of sick and poor, seem so painfully obvious to me as I think about Lydia's life and death. Recognizing and defining the limits of the clinic seems essential for providers. Because the clinic in many ways does not actually change the existing social power dynamics; one person in power is helping and the other is being helped. Patients are still relatively powerless, lacking the social, educational and cultural capital to reverse the oppressive structural conditions in their own lives. Patienthood is an often powerless condition, as healthcare professionals and patients both know. How could Lydia have been empowered to guide and participate in her own well-being and health without being blamed for having neglected it? And how does the essential conservatism, the boundedness of the medical profession, cloaked under notions of professionalism and safety, keep us from engaging in the truly humane care of those we take care of and to be able to actualize their dreams?

In chapter six, I wrote about Lydia's life-in-death. I wrote about how I brought her to the post-incarceration clinic which I helped start and which I believe does important work. I think having a clinic that is devoted to providing excellent, nonjudgmental care to people with

histories of incarceration is important. I think having an awareness of stigma and lack of trust that are so common to both drug use and incarceration can hopefully make us more understanding and accessible practitioners. But providing excellent clinical care to what doctors call “hard-to-reach” populations can only come with the democratization of healthcare in which we envision providing health in ways in which the clinic is not so central. We should be employing people with histories of incarceration in the care of others as community health workers or in other capacities. We should be paying them to go to college and harness the many kinds of experiences they have had in their lives. The mental health and addiction recovery field firmly hews to the notion that life experience and experiences of recovery make these individuals more effective counselors and supports than others who do not have these experiences.

Such a model creates new spaces for care and engagement that, simply speaking, doctors cannot initiate. Primary care doctors don’t have the time to walk Lydia through the two buses she needs to take and the anxieties she has in order to get to the clinic. We should be shifting our energies to creating these jobs in a sustainable way (for example, at the Transitions Clinic in San Francisco, community health workers were funded via grants and “proved” their cost-effectiveness to San Francisco County, who now pays their salaries). Shifting to community health workers reminds us that seemingly simple interventions like accompaniment (Farmer et al. 2006) can and should be utilized here at home.

Global Health At Home

As “global health” becomes a buzzword, entering households and appealing to individuals previously untouched by medical anthropology or social medicine, it has become increasingly important for me to resist the call to explore the suffering of others on distant shores. I have

always been interested in thinking critically about local injustices and inequality here in the United States, dating back to my education as an AIDS activist as an undergraduate in Columbia in New York City. I learned about activism from drug users, homeless individuals, formerly incarcerated folk and people who had mobilized for the sake of their lives during the 1980s HIV epidemic. These are people who are part of our social compact, with whom we have shared futures and some common histories. Our fates are knit together by fact of geography but also common governance and policies and cultural orientations. I increasingly felt a tension between what was “global health” and the work that I did on healthcare among the disenfranchised and precariously positioned here in Boston. One could be committed to the health of others (in Zambia) and was that enough of a commitment?

Through the pursuit of this work, I perceived that the study of suffering of local people was eclipsed and less interesting (less fundable) than the suffering of a more exotic other, even though health disparities and stark inequalities exist here at home. Among hierarchies of suffering and hardship, maybe the suffering of incarcerated women addicted to heroin was deemed less dire and less gut-wrenching than the suffering of a poor woman with cancer in rural Cambodia. Was one woman’s life necessarily better, more happy (was there more flourishing or ability to do so)? Was the texture of poverty somehow different since it was more materially well-off or desperate in a different way? Because these women had cell phones and Facebook and sometimes televisions? It always felt as if my “subjects,” because of the chance of their birth, were somehow less worthy of serious study and concern.

But to study social suffering close to home is an equally complex, perhaps arguably more difficult, enterprise than to travel abroad. It is messier to separate out the forces at play when they are something that we see everyday, that we become used to not seeing. So my project was

partly motivated by a desire to speak against this imputed hierarchy of suffering. I have endeavored to show that poor women in the prison system are complex, interesting, morally worthy of study and advocacy. They constantly affirmed that their lives were interesting. They wanted to be studied and were grateful to be heard and acknowledged, to have their stories used to teach others and reflect on human experience. They believed in the value of their lives and their stories.

I did notice that many insights that my global health colleagues made seemed relevant in the United States as well. In the study of prisons and incarceration, I became aware that increasing economic inequality was a key driver in the politics of safety that manifested in “law and order” legislation to contain and quell the fomenting rebellion of the disenfranchised. The United States was plagued by spiritual insecurity and increasing economic inequality (made more apparent by the economic recession of 2007) having many of the characteristics of “millennial capitalism—that odd fusion of modern and postmodern, of hope and hopelessness, of utility and futility, of promise and its perversions” (Comaroff and Comaroff 1999: 283).

Contemporary ethnographic reports of spiritual insecurity and embodied distress about how to manage life itself are common as medical anthropologists investigate how individuals come to know and manage the uneven playing field in which they live (Scheper-Hughes 1993; Garcia 2010; Han 2012; Abramowitz 2009; Desjarlais 1997; Benson 2009). Increasingly, anthropologists were concerned about how one made oneself visible to the state; how did one’s sickness force recognition, compensation, medical care, simple acknowledgement of one’s existence? How did it define oneself as someone worthy of human or legal rights—of recognition, political legitimacy, of care (Tiktin 2006; Fassin 2007; Petryna 2002; Nguyen 2010; James 2010), resulting in new emphases regarding notions of citizenship and belonging—

therapeutic citizenship, biological citizenship, traumatic citizenship, humanitarian citizenship, the list goes on?

I noticed that when prisons in the United States were concerned, there was the opposite kind of process happening. Rather than individuals seeking rights, legitimacy and acknowledgment in the context of relative lack, there was a mass attenuation of citizenship in the form of banishment from the polis. It was the unmaking of citizens, stripping people of their rights to vote, to live in public housing and condemning them roundly to lives of political and social marginality and the perpetual shroud of stigma. Giorgio Agamben's work on bare life—and the “life that does not deserve to live”—is relevant here, ringing of Foucault's notion of “indirect murder” that I discussed in the chapter on Lydia's life (see Smith 2010 for a useful feminist interpretation of Agamben and welfare policies).

Agamben's interpretation of “the age of biopolitics” was that power had the right to “decide the point at which life ceases to be politically relevant” (1998:142). Agamben proposed that the concentration camp was “the space that is opened when the state of exception begins to become the rule” (1998: 168-169). Is the prison the modern-day camp, insofar as those incarcerated lose voting rights, face fines and fees, face the loss of economic livelihood, their ability to live and prosper itself jeopardized? As Lisa Stevenson writes about her work with the Eskimo using Agamben, “Bare life is... a life (any life) that is always already exposed to an anonymous death” (2012:588). Women like Lydia leaving prison are our society's anonymous people exposed to anonymous deaths.

Does it have to be this way? Organizers and activists launching campaigns against incarceration, against the criminalization of drug use, and for social, racial, sexual and economic justice are fighting against exposure to “anonymous death” in myriad ways. Drug Policy

Alliance, WORTH (Women on the Rise Telling Their Story), Homeboy Industries, Delancey Street Foundation, VOCAL-NY, EPOCA (Ex Prisoners Organizing for Community Advancement), Families for Justice as Healing, Harm Reduction Coalition, Black and Pink, ACT-UP, Law Enforcement Against Prohibition, Drug Policy Alliance, Critical Resistance, the list could go on. People in their churches, working groups and just meeting as concerned individuals are standing up against the macro-political forces that coalesce and seem to conspire against their livelihoods and life itself, the Occupy movement has shown. There are movements resisting the building of jails and prisons in Pennsylvania and against the dehumanizing shackling of incarcerated women when they are giving birth.

In California, there is a strong move to resist the turn to “gender responsive” rhetoric used to build more prisons and jails for women; as Cynthia Chandler of Justice Now writes, of California’s Gender Responsive Strategies Commission’s suggestion to build 4500 new prison beds for women who were deemed low-risk: “This model is dangerous to incarcerated women because it embeds a mix of paternalism and imperialism, racism and classism—all promoting the idea that prisons can be safe, respectful, dignified places where we can do what’s best for our “downtrodden” sisters. The model includes no critique of prisons or the role prisons have played in dominating poor women and women of color” (2010: 332). Others are raising awareness of and protesting the anonymous deaths of loved ones held in federal and local immigration detention facilities. And even in little ways, people are getting out and saying no to “business as usual.”

Harry Leno, a tattooed pierced man with long white hair wearing a Veterans for Peace t-shirt, is one such man. He heads out to Lowell and Lawrence, two North Shore suburbs, every Tuesday with packs of needles, ties, cookers, Band-Aids, and red sharps containers. Handing

them out of the back of his beater car, he reliably meets heroin addicts every week to provide them with clean supplies while taking back their dirty needles in the sharps containers. He goes out every week with a woman with an MPH from Boston University who does the accounting. They call themselves “Love and Safety.”

Lawrence is a town in disarray. Like Lowell, it is a post-industrial mill town, but unlike Lowell, it does not have the university to boost its local economy. People have told me that Lawrence is the closest thing to an open-air drug market near Boston; many people drive from around the eastern part of the state to buy heroin or opiate pills in Lawrence. Lawrence feels like a ghost town when Harry and I get there. The tired dusty downtown had only a handful of open storefronts. We quickly find a rooming house—where people pay by the week for individual rooms with shared bathrooms in the hallway—and visit two of the people in the building to give them sharps containers and collect their sharps containers with used needles. Harry tells me his strategy for finding addicts is via the “seek and find” method. He goes to them wherever they are, living under flatbed trucks, in “empties,” or in rooming houses or just walking around on the street. He used to give needles out to an executive who used to fly back and forth all the time from Greece.

“Love and Safety” never knows how many clean needles it will be able to give out. This is because they never have a constant supply of needles. They rarely have the much-requested bacitracin packets that addicts apply to try to prevent skin infections (the bacitracin is too expensive, but Harry and Stacy do give out alcohol wipes). Harry and Stacy can hand out upwards of 2000 needles a day, easily taking back sharps containers with the same amount. But their supply is limited, and they constantly worry about not having enough for their regular clients. Addicts tell them new places to go—“you know, you guys should hit up Apple Street,

there's a lot of people that need these"—but Harry is loath to expand without knowing if he will have enough to expand responsibly. They don't have nearly enough of the overdose medication Narcan that can prevent overdose fatalities.

Technically, giving out clean needles is no longer illegal in Massachusetts, although in the past, Harry has been hassled and arrested for “possession” (of drug paraphernalia) since he has been doing this work since AIDS epidemic began to hit hard. He began in Boston—Roxbury, Chelsea—neighborhoods hit hard by poverty. Harry laments that no one else is “seeking and finding.” What he means is that no one is proactive or imaginative enough to envision or enact a paradigm shift one user and a time. Addicts are generally told to come into clinics or to hospitals or to drop-in centers to get clean needles, but Harry knows the large majority won't come in, generally out of a mixture of shame and stigma. Many people would rather re-using a dirty needle until it becomes so blunt that using it is like stabbing oneself with a fork. Or she might even use a friend's needle, who promises that he is clean, than go into a clinic and have to ask for needles, trying to hide the track marks and the runny nose and trying to ignore the puritanical looks from the nurses. But Harry's supply is constantly limited and he is a small part of an ongoing endless war on drug users. He is not discouraged, though, and many of the women that I met in prison and jail knew Harry as the old man with needles. He didn't judge them and they credit their relative health and well-being to his kindness, his weekly commitments to them, his acknowledgment of their common humanity.

The Evolving Landscape of the “War on Drugs”

Many have suggested that now is a critical time for shifting policy and cultural orientations towards both drug use and incarceration. Across the country, there is an evolving attitude and legislation towards marijuana, a drug that has a critical place in the history,

production and cultural responses to the punitive War on Drugs. Marijuana is still the number one reason for drug arrests in this country, accounting for over half of all drug arrests; there were 8.2 million marijuana arrests between 2001 and 2010, and 88% were for simple possession (American Civil Liberties Union 2013). Marijuana was a crucial drug that the Federal Bureau of Narcotics used as a hinge into the American psyche; it played on people's xenophobia (i.e., fears of Mexican men high on marijuana raping white women).

In Massachusetts, there was recently a vigorous debate over making medical marijuana legal in 2012, and it solidly passed with 63 percent in favor. The devil was in the details, the opponents argued. The Massachusetts Prevention Alliance argued against it: "This is not about the terminally ill—it is about widespread marijuana abuse." The proponents leveraged language like "compassionate medicine." At a "listening session" held by the Department of Public Health about how to implement the new law, young combat veterans from Iraq and individuals with ALS and MS who used marijuana to ease their suffering and help bring sleep were pitted against middle-aged white women and old-school law enforcement officials.

The mothers of children on heroin showed up in droves in their substance abuse coalitions on the South Shore and South Boston. They mentioned how even tightly regulated drugs like Oxycontin made their way into the streets, noting the rise of "heroin related drug crimes" and the "increased risk of home break-ins." So this was the link between marijuana, heroin and crime as it lives in the public imaginary? I wondered how shifts in attitudes towards marijuana and increasingly legalization would shift subsequent attitudes and policies towards "hard" drugs? In fact, I worry that they might not; my research suggests that heroin is an easy scapegoat for all social problems and has traditionally filled this role. But things are certainly

shifting with regard to marijuana policy and public opinion. What are the implications of the Department of Public Health legislating and regulating drugs and their consumption?

The orientation of the War on Drugs is changing and those who are proponents of its militancy are even suggesting a turn to “public health.” And many prisons are closing down and many more are plagued—unable to do the business of incarceration—by overcrowding or the scandal of privatization and contracts for keeping beds full (Chang 2012; Blow 2012). During my fieldwork, I attended a conference in New York City on the potential implications of the shifting public opinion tides on the War on Drugs and women at the New York Academy of Medicine (NYAM) sponsored by the Drug Policy Alliance (DPA) and WORTH (Women on The Rise Telling Herstory). The conference brought together formerly incarcerated women, direct service providers, researchers, policy analysts, and advocates and activists to discuss how to move from a criminalization model of drug use to a public health model: “More than a failure, the war on drugs has swollen the prison system, left millions of people with criminal records and damaged communities.” Their one-day conference was aimed at exploring “practical examples of public health alternatives” –through discussions around four main themes: prevention, treatment, harm reduction and safety.

What was interesting to me during the panel sessions and the break-out groups was the relative absence of public health professionals and clinicians in these discussions (one notable exception was Professor Lynn Roberts of Hunter College’s Department of Community Health). While “public health” was one of the buzzwords of the day, it seemed to stand in for other things that the conference attendees were actually more interested in talking about: structural violence, poverty, racism, patriarchy—often referred to as the “structural determinants of health.” One possibility is that “public health” was being used rhetorically as a means to talk publicly and

politically about race, class, gender and various axes of social inequality under “public health’s” seeming cloak of respectability.

There was some discussion of specific legislation and public-health oriented programming by several of the speakers—for example, Good Samaritan Acts to not prosecute 911 callers reporting overdoses, needle exchange programs, the decriminalization of sex work, and bills against the criminalization of HIV status—but the conference neglected how the massive apparatus of the War on Drugs endeavor will be “public health-ified” on a large scale. And what does the term “public health approach” to addiction actually mean? Recently, the Obama administration made pronouncements on the War on Drugs with the 2013 release of their National Drug Control Strategy. Gil Kerlikowske, the Obama Drug Czar, stressed the importance of a “public health approach,” saying, “Drug policy reform should be rooted in neuroscience—not political science. It should be a public health issue, not just a criminal justice issue. That’s what a 21st century approach to drug policy looks like” (The White House 2013). Yet as Gabriel Sayegh of the Drug Policy Alliance pointed out, the plan was really that the President’s “public health approach is going to be through drug courts.” Sayegh noted that this is not really a public health approach; rather, it represents a refusal to entirely let go of the criminalization model “since it lets judges, prosecutors and cops continue to say what a health-based approach is.”

And how exactly is a health-based approach and how does it differ from a public health approach? This distinction between public health and clinical medicine is critical. The two fields have historical and ongoing accommodations and antagonisms—to use historian of medicine Allan Brandt’s terms (Brandt and Gardner 2000)—as well as important philosophical, methodological and empirical differences between them. In reference to the War on Drugs, does a “health-based” approach mean that drug use is a problem primarily to be solved within the

confines of a doctor-patient relationship? Does it mean that all addiction treatment (inpatient, outpatient and residential) should be billable and insurable? Does it include peer-recovery or finding God and salvation or under its rubric? How is a “public health” approach different from a predominantly clinical orientation?

Public health/medicine and criminalization have a long history in the United States of jockeying to be the dominant paradigms for addressing addiction and drug use. And I generally agree that a public health paradigm is a better, safer and more humane alternative than the current criminalization of drug use. But does the public health field even want to “own” addiction as one of its many causes, when addiction can be seen as a sociocultural phenomenon, even an epistemological stance towards the world, just as much as it can be seen as a problem for population health? How does addiction fit into the traditional public health realms of biostatistics, infectious disease, environmental exposures and epidemiology: is it actually “contagious” or catching the way that so many “moral panics” suggest?

Eva Bertram and her colleagues make a convincing argument in their 1996 book, *Drug War Politics: The Price of Denial*, for a turn to public health. As they argue,

First, a clinical, medical approach to many health problems is insufficient. Second, it is far more effective-and, in the case of health problems without a cure, absolutely imperative—to prevent rather than to treat many health problems. Third, prevention demands attention to the physical and social environment that causes or exacerbates health problems. And fourth, attention to the broader environment demands a response by the public; it is beyond the control of individuals alone and beyond the reach of physicians (Bertram et al. 1996:194).

As politicians and advocates move forward in advancing an agenda in which incarceration is not the main form of “treatment” for addiction, and as we undergo many of the changes laid out in the Affordable Care Act, we need to be careful about how we speak about public health and addiction. Public health, at its worst, studies and measures “health behaviors” (of individuals) and demands a ceaseless supply of behavioral studies to demonstrate both effectiveness and

efficacy of interventions. Some public health interventions can engage in fear-mongering and produce risk, blame, shame and fear in their efforts, identifying “risky” lifestyles and behaviors as we continually learn with the HIV epidemic. At its best, public health projects can address the complex etiology and interactions between individuals and their environments as well as focusing on the “upstream” societal factors—poverty and inequality, to name a few—that are such important forces in determining the life chances of the poor and disadvantaged.

One source of indeterminacy is that changing the way we as a society envision and grapple with drug use means we have to become more comfortable with risk. Many of the women I worked with had repeatedly engaged in self-destructive behavior that has posed serious and substantial risks to themselves and others (one woman drove a school bus of children to school every day, and justified it because her own infant daughter was also onboard). But as I have endeavored to show here, they often pose these risks to themselves and others out of shame, defiance, stigma and lack of humane treatment at the hands of prisons and others. By attending to the prevention of drug use, expanding compassionate treatment, engaging in harm reduction that can reduce stigma as well as embodied risks such as HIV, and legalizing drugs to take them out of the shadows, we can try to minimize the risks to users and to the public at large.

In these efforts, we need to closely examine not only prisons and drug treatment and our often unhealthy policies but what the effects might be of our own well-intentioned responses to addiction; as Arthur Kleinman has written, “Institutional practices make health and social problems more intractable and deepen both the sense and substance of misery. At the same time, narrow technical categories strip away the moral significance of these problems, and practitioners appropriate the authentic voices of sufferers for their own institutional ends...

Sometimes this transformation [of a moral problem into ... a medical one] is helpful, and at other times it is not” (1999: 392).

Yet being vigilant about the possibilities of our responses is not a reason for inaction. Rather, we must seek to be more imaginative and critically engaged in little and big ways, in the clinic and beyond. We must partner with and learn from those most affected, and we must speak out, working towards a world where doing justice does not involve prisons. One of the doctors I worked with when I visited Cook County Jail in Chicago called the jail a “factory of sorrows.” Against factories of sorrows everywhere I have struggled to show in great detail the institutional sources of sorrow and suffering in our midst.

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